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Sonoma Medicine

INTERVIEW

SCMA President Regina Sullivan, MD

FEATURE ARTICLES

The Opioid Epidemic

The magazine of the Sonoma County Medical Association

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Volume 67, Number 3 Summer 2016

Sonoma Medicine

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Reducing Opioid Prescriptions

Mary Maddux-González, MD

Seventy-eight Americans die every day from an opioid overdose, and more than half of these overdoses involve an opioid prescribed by a physician. Since 1999, both opioid prescriptions and opioid overdose deaths have quadrupled. Meanwhile, evidence is mounting that opioid pain medications are less efficacious than initially thought for chronic pain management. Indeed, we now know that opioids can worsen pain at higher doses and are associated with an increasing number of serious adverse health effects.

How are we doing in Sonoma County in terms of physician prescriptions for opioids? Unfortunately, our local rates of opioid prescriptions, of residents on high daily doses, and of opioid/benzodiazepine prescriptions exceed statewide rates. On the positive side, many local efforts are underway to reduce what has become an unsafe community standard of practice for opioid prescribing. The articles in this edition of *Sonoma Medicine* highlight some of these efforts.

Epidemiologist Sarah Katz and her colleagues at the Sonoma County public health department provide a detailed review of county data on opioid use, as well as an overview of the department's efforts and collaborative initiatives to address the opioid epidemic. Dr. Marshall Kubota, regional medical director for Partnership HealthPlan of California, presents the significant progress that PHC has made in reducing the number of opioid prescriptions and the number of patients on high doses of opioids in Sonoma County.

Dr. Gary Pace, chief medical officer of Alexander Valley Healthcare, discusses medication-assisted treatment for opioid addiction, including current research on addiction and brain chemistry. He challenges our biases as a medical community regarding addiction and recovery, particularly when that addiction is iatrogenic. Dr. Erin Lund describes the New Beginnings Clinic at Santa Rosa Community Health Center, which cares for the increasing number of pregnant women with opioid use disorder. The clinic serves as an excellent model of integrated medical and behavioral health care that promotes regular prenatal care, medication-assisted treatment, favorable pregnancy outcomes and reduced rates of neonatal abstinence syndrome.

As we move together as a medical community to reverse the overprescribing of opioid medications, we need to ensure that we don't restrict access to appropriate use of these medications. Dr. Bo Greaves addresses this topic in a thoughtful and compassionate manner.

The Sonoma County Medical Association has joined forces with other local health care leaders to address the opioid epidemic. SCMA is a member of the Opioid Prescribing Work Group chaired by Sonoma County Health Officer Dr. Karen Milman and Dr. Lisa Ward, chief medical officer of Santa Rosa Community Health Centers. Physician leaders from SCMA, Annadel, NCMA, Sutter, TPMG, community health centers, PHC and the public health department are working together to develop guidelines that support consistent and safe primary care opioid prescribing practices across our community. On a parallel track, physicians and other leadership from St. Joseph's, Kaiser, Sutter and district hospitals are developing community-wide emergency department guidelines for safe opioid use. A consistent community standard of practice across primary care and emergency departments, supported by evidence-based prescribing guidelines, will increase patient safety while reducing "doctor shopping," "ER shopping" and other drug-seeking behaviors.

Unfortunately, physicians have played a central role in what is largely an iatrogenic epidemic of opioid addiction and overdose deaths. This fact weighs heavily on physicians who have prescribed these medications in a genuine effort to do right by providing their patients with relief from pain. In recent years, physician decisions to increase their prescribing of opioids were heavily influenced by the active promotion of opioids, not only by pharmaceutical companies, but also by state medical boards, national health care agencies and professional medical associations. These well-intentioned but poorly informed policies and practices have led to the dramatic increase in the availability of prescription opioids in Sonoma County and elsewhere, with the accompanying negative consequences of addiction, diversion and overdose deaths.

To protect the health and safety of patients, physicians need to play a central role in reversing ill-informed and unsafe opioid policies and prescribing practices. SCMA is pleased to offer this special issue of *Sonoma Medicine* on the opioid epidemic, and we will continue to work collectively with the medical community in Sonoma County to address this important issue. ◇

Dr. Maddux-González, chief medical officer for the Redwood Community Healthcare Coalition, is the immediate past president of SCMA.

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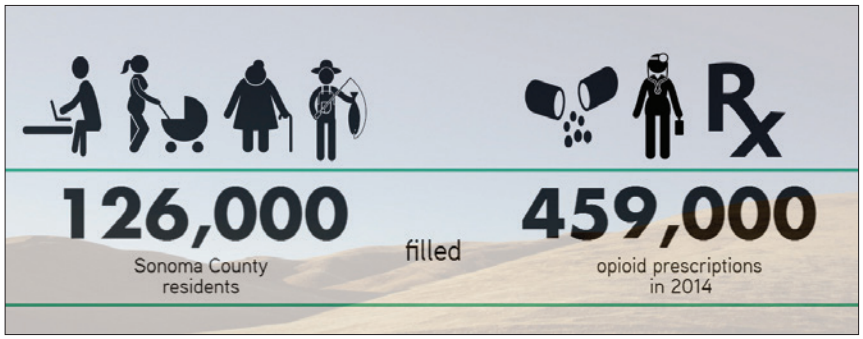
The Opioid Epidemic in Sonoma County

Sarah Katz, MPH, Arielle Kubu-Jones, Karen Milman, MD, MPH, Melissa Struzzo, MPH, Terese Voge, MPA



The misuse and abuse of drugs, particularly prescription opioids, is a growing problem in Sonoma County, the state of California and the United States. Overdose deaths from drugs obtained both legally and illegally now exceed all other causes of injury-related deaths both locally and nationally, and they take more lives than traffic accidents.

Nationally, more than 47,000 drug overdose deaths occurred during 2014—higher than any previous year on record. Since 2000, the age-adjusted drug overdose death rate has more than doubled (from 6.2 to 14.7 per 100,000 residents), and the rate for deaths from prescription opioids has nearly quadrupled (from 1.4 to 5.1 per 100,000 residents).[1]

In California, more than 12,500 residents died from drug overdoses from 2011 to 2013. The crude rate of overdose deaths from drugs obtained both legally and illegally, and all intents, was 11.0 per 100,000 residents.[2] During the same time period, prescription opioid overuse and overdose led to 4,200 deaths, with a crude death rate of 3.7 per 100,000 residents.[3] The age-adjusted rate of deaths related to prescription opioids increased by 16% from 2006 to 2013; the rate of deaths related to heroin increased by 67%. In 2013, the death rate for overdose due to heroin was 1.3 per 100,000 residents.[2,3]

Sonoma County Data

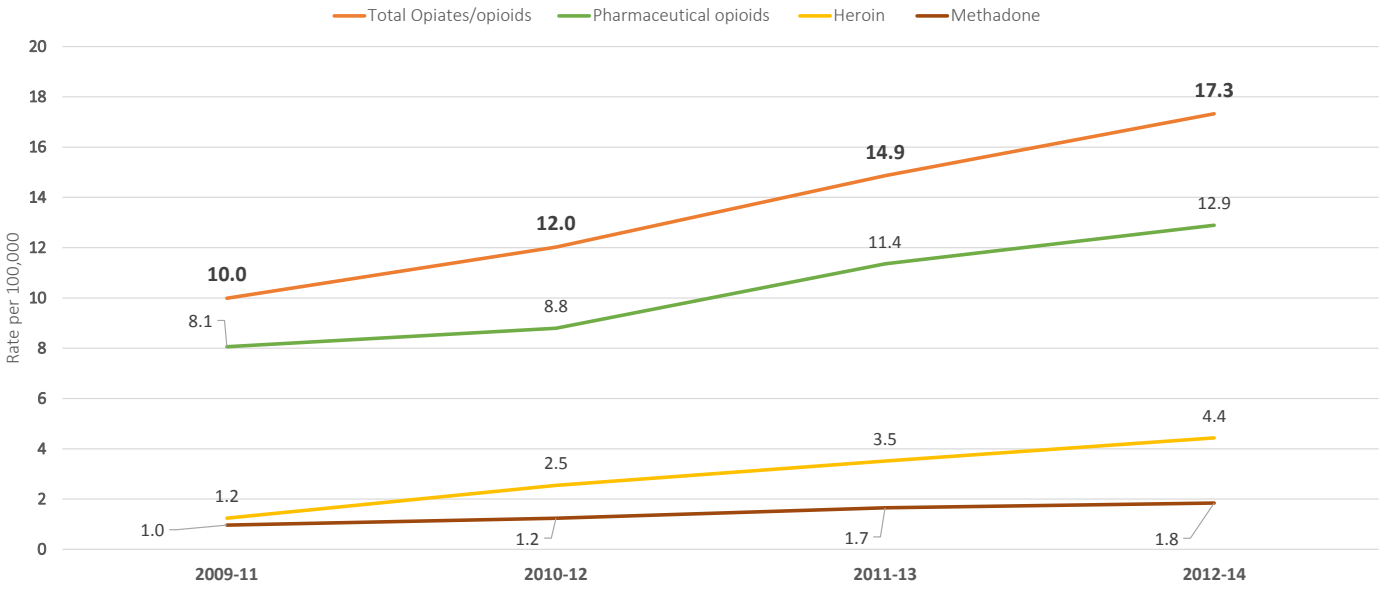
Opioid-related data in Sonoma County range from near real-time electronic death-certificate surveillance to less timely injury data from the California Department of Public Health. These differences in release time mean that 2015 Sonoma County data is available, but not comparable data for California. Every effort has been made to obtain the most current and relevant data, but direct comparisons between Sonoma County and California are not always possible.

More than 900 Sonoma County residents died from a drug overdose in the past 15 years. In 2011–2013, the crude rate of overdose deaths from drugs obtained both legally and illegally, and from all intents, was 10.3 per 100,000 residents.[2,3] The most recent local data (2013–2015) indicate that, on average, one Sonoma County resident dies every week from a drug overdose.[4] From 2000–2002 to 2010–2012, the age-adjusted drug overdose death rate increased significantly for both Sonoma County and California. In 2010–2012, the rate in Sonoma County (12.0 per 100,000 residents) was higher than in California (10.1 per 100,000 residents).

In 2011–2013, drug overdose was the leading cause of injury death in Sonoma County, with overdoses causing more than twice the number of deaths as motor vehicle accidents. More than 80% of Sonoma County's drug overdose deaths were unintentional. Almost half of these deaths were among people 45–59 years of age, and the vast majority

The authors work for the Sonoma County Department of Health Services. Ms. Katz and Ms. Voge are health program managers; Ms. Kubu-Jones is administrative support; Dr. Milman is the public health officer; Ms. Struzzo is a health information specialist.

Figure 1. Rate of non-fatal, treat and release, emergency department (ED) visits for unintentional drug poisoning due to opiates,* 3-year rolling average, Sonoma County, 2009-11 to 2012-14



Data source: California (CA) Office of Statewide Health Planning and Development (OSHPD) non-public Emergency Department Data (EDD), 2009-2014 and CA Department of Finance Report E-4, Population Estimates for Cities, Counties, and the State, 2011-2015 with 2010 Benchmark, released May 1, 2015. Analyses conducted by Sonoma County DHS.

Data note: *Included only if opiates were listed as the principal external cause for the ED visit

were among white, non-Hispanic residents. At least one in three drug overdose deaths was due to prescription opioids; the crude rate of these deaths was 3.5 per 100,000 residents.[5] (These data likely underestimate the true number of prescription opioid deaths; the type of drugs involved in drug overdose deaths are not always known or reported on death certificates.)

Sonoma County has also seen increasing morbidity as a result of drug overdose. From 2011–2014, there were at least 660 non-fatal opioid-related emergency department visits.[6] (As with prescription opioid deaths, these data likely underestimate the true number of opioid-related ED visits; the drugs involved in ED visits are not always known or reported.) From 2009–11 to 2012–14, the rate of nonfatal treat-and-release ED visits for unintentional drug poisoning due to opiates increased by 73%, from 10.0 per 100,000 residents in 2009–11 to 17.3 per 100,000 residents in 2012–14 (Figure 1). The age-adjusted rate for this type of ED visit was statistically higher in Sonoma County (15.8 per 100,000 residents) than in California (9.8 per 100,000 residents).

Pharmaceutical opioids were the principal cause for about three-quarters of these ED visits; heroin was the principal cause for about one-quarter. Notably, the ED visit rate for heroin increased 267% from 2009–11 to 2012–14.[7] Though the abuse of illicit opioids like heroin is outside the scope of this article, the Sonoma County Department of Health Services (DHS) is monitoring heroin trends and is committed to reducing the use of heroin county-wide.

CURES Data

In 2015, the Committee for Health Care Improvement, part of Health Action, the county-wide coalition of stakeholders working to improve health across the county, formed the Sonoma County Opioid Prescribing Work Group to guide policy and systems changes. The group's first task was to analyze 2014 data on Sonoma County opioid prescribing patterns from California's controlled substance utilization review and evaluation system (CURES). The group's finding s included:

- Approximately 459,000 opioid prescriptions were prescribed to about 126,000 unique Sonoma County residents during 2014, or 25% of all county residents.
- The prevalence of prescription opioid use decreased with age, as shown by the percentage of each age group that received at least one opioid prescription in 2014. For residents 65 years or older the prevalence was 41%, followed by 55–64 (34%), 45–54 (31%), 35–44 (26%), 25–34 (25%) and 18–24 (19%). Only 4% of residents under 18 years received at least one opioid prescription.
- Fifty-eight percent of Sonoma County residents with an opioid prescription were female.
- Hydrocodone (57%), oxycodone (18%) and morphine (7%) were the most frequently prescribed opioids.[8]

Meanwhile, the California Health Care Foundation (CHCF), using 2010–13 data from CURES, found that Sonoma County consistently had a higher rate of opioid prescriptions than the state average during that time period. (Buprenorphine was excluded because its use for pain is trivial statistically, compared to its use for addiction.) In 2013, Sonoma County's rate was 885 opioid prescriptions per 1,000 residents, compared to 563 prescriptions per 1,000 residents in California. The rates were not age-adjusted, however, so the higher median age in Sonoma County may account

for some of the difference between the two rates.

CURES tracks whether an individual patient has been on a daily dosage of 100 MME (morphine milligram equivalents) for 30 or more days, and whether the patient has been on a combination opioid and benzodiazepine prescription for 30 or more days. CHCF also analyzed 2010–13 data from these two measures. (In the forthcoming CURES 2.0, providers will receive alerts for these two measures and three others.) CHCF found that:

- From 2010 to 2013, the rate of Sonoma County residents on a 100 MME daily dosage for 30 or more days was almost double California's rate; in 2013, the Sonoma County rate was 15 per 1,000 residents and the California rate was 8 per 1,000 residents.
- In 2013, about 13 per 1,000 residents in Sonoma County were on combination opioid and benzodiazepine prescriptions for 30 or more days, compared to 9 per 1,000 California residents.

These various analyses of CURES data represent a first effort to contextualize opioid prescription users in Sonoma County. DHS will continue monitoring opioid prescribing and drug overdose data to better understand and describe the local factors associated with the county's growing opioid epidemic. The data will guide local work on the epidemic, track local changes in prescribing patterns, and evaluate the impact of existing and future efforts.

Increasing Opioid Safety

In Sonoma County, various coalitions, health care providers, and work groups are using specific interventions to increase opioid safety and prevent and treat the misuse of opioids. These interventions include:

Prescribing Guidelines. The Opioid Prescribing Work Group described above is a partnership of health care organizations, providers, government agencies and community groups who came together to coordinate a unified plan for medical management of opioid use and abuse in Sonoma County. The work group is endeavoring to create and adopt standardized guidelines for primary care providers and hospital emergency departments across the county. The guidelines will serve as a vital clinical tool to reduce opioid morbidity and mortality. Implementation of the guidelines is expected to start in early fall 2016, with the goal of having at least 60% of the county's primary care providers and all its hospital emergency departments fully participating by May 2017.

Regional Opioid Safety Coalition Grant. The Redwood Community Health Coalition (RCHC) received a grant from the California HealthCare Foundation in 2015 to increase opioid safety through a collaboration of community partners, including Partnership HealthPlan, community health centers, hospitals and Sonoma County DHS. The project features three main interventions:

- Partnering with the Opioid Prescribing Work Group to support safe prescribing practices by developing and implementing common opioid prescribing guidelines among primary care providers and hospital emergency departments in Sonoma County.
- Expanding access to buprenorphine (Subutex) and buprenorphine/naloxone (Suboxone) for RCHC patients. These drugs are approved by the FDA for treating opiate addiction.
- Developing policies, procedures and funding options to ensure access to naloxone (an opiate antagonist) for opioid overdose prevention in Partnership HealthPlan managed care Medi-Cal patients.

CURES 2.0. By law, all prescribing clinicians are required to register for CURES 2.0 by July 1, 2016. The current draft of the Opioid Prescribing Work Group's guidelines recommends using CURES 2.0 as a monitoring tool for identifying potential misuse. As mentioned before, a new feature of CURES 2.0 is an alert system that can send automatic notifications to prescribers for their patients who fit certain scenarios, such as taking 100 MMEs daily or using a combination of opioids and benzodiazepine.

Drug Medi-Cal Expansion. California plans to test a pilot program for expanding services to Medi-Cal patients with substance use disorders. Sonoma County has applied to be included in the pilot, and if its request is approved, implementation is anticipated to begin by 2017. The expanded services would be provided by Sonoma County Behavioral Health and contracted providers. In addition, residential treatment facilities with more than 16 beds that are currently ineligible for Medi-Cal funding would become eligible for reimbursement.

Safe Medicine Disposal. Disposing of personal medications is a recognized strategy for preventing opioid abuse. Research shows that 21% of the people who use medications for non-medical reasons obtain them from a doctor, and 64% obtain them from a friend or relative.[9] These statistics underline the importance of safe disposal options for keeping medications out of the wrong hands. Fortunately, Sonoma County has an active disposal program for expired, unused and unwanted prescriptions and over-the-counter medications. The program uses mailbox-style bins at hospitals, law enforcement offices, senior centers and medical clinics in certain Sonoma County locations. (For a list of locations, visit www.safemedicinedisposal.org.) Not all bin locations are able to accept controlled substances, but program partners are working to ensure greater access to bins that can accept those substances.

A Long Road Ahead

No single approach can solve the opioid epidemic; it is a public health problem that must be tackled from every angle. Sonoma County is using a multifaceted, public health-based approach, which includes working with health care providers to adopt uniform prescribing practices, advocating for medication-assisted treatment, getting unwanted opioids out of the home, and increasing access to treatment for people with substance use disorders. People involved with health care in Sonoma County need to strengthen and expand

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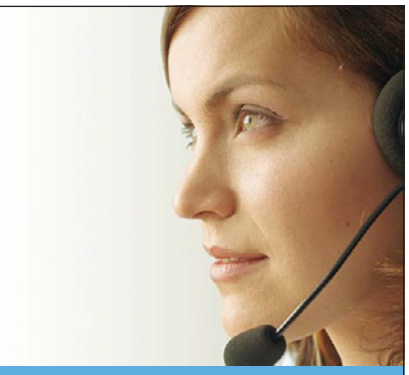

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Unintentional drug poisoning in Sonoma County, *www.sonoma-county.org/health/publications*

Understanding the epidemic through data, *www.chcf.org/oscn/data*

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Email: sarah.katz@sonoma-county.org

Managing Pain Safely

Marshall Kubota, MD

Amid all the grim statistics about prescription drug abuse, here's a happy one: Partnership HealthPlan of California has achieved a 40–50% reduction in opioid use throughout our service area since 2014. PHC is a nonprofit health plan that began administering the Medi-Cal benefit in Sonoma County in 2009; the plan also administers Medi-Cal benefits in 13 other Northern California counties. There are more than 110,000 PHC members in Sonoma County, and they account for 22% of the county's population.

In 2013, Medi-Cal published a retrospective analysis of opioid use in its fee-for-service patients from May 2010 to April 2011.[1] During that period, 12% of Medi-Cal FFS patients used opioids. Within the 40–64 age group, more than a third (34%) received at least one opioid prescription; for the 19–39 age group, the rate was 18%. Opioid drugs accounted for 5.5% of all retail claims and 4.5% of total dollars paid. Half of all opioid claims were for hydrocodone.

There are many consequences for such high prescribing rates. At the capstone of the pyramid of opioid use are the overdoses and deaths. Sonoma County drug overdose mortality rates (12/100,000) are slightly more than the state average (11/100K), but several PHC counties had far higher death rates, including Lake (46/100K), Humboldt (33/100K), and Mendocino (20/100K).[2]

Dr. Kubota, a Santa Rosa family physician, is a regional medical director for Partnership HealthPlan of California.

Beneath the capstone are many patients on dangerously high, ineffective doses that are doing more harm than good. Lacking objective measurement of pain, clinicians are uncertain who has pain, how much, and whether the patient is abusing or diverting medications. Much of the problem began in an earlier era, and younger clinicians feel like they have inherited it. True in part, but an analysis by PHC showed that over six months' time in 2014, approximately 30% of PHC members already receiving opioid doses greater than 120 MEDs (morphine equivalent doses) got a dose increase during that period.

PHC began addressing the opioid prescription problem with a meeting of local medical directors in 2010. In fall 2012, the health plan brought the problem to the front of the local health care stage by sponsoring conferences that featured local pain specialist Dr. Andrea Rubinstein. In 2013, PHC began the Managing Pain Safely (MPS) initiative, which has led to the 40–50% reduction in opioid use mentioned earlier.

PHC developed short- and long-term goals for the MPS initiative with input from internal and external advisory committees, along with results of a prescriber survey. Pharmacy policy was the primary focus. In October 2014, PHC implemented a 120 MED/day threshold for individual medications and a 40 mg/day limit for methadone because of QT prolongation concerns. Refill periodicity was narrowed to prevent 13-month refill years. Prior authorizations were required for drug escalations. Such escalations were considered a temporary measure.

Meanwhile, PHC provided medical offices with up-to-date information on the prescription opioids obtained by Medi-Cal patients who are assigned to that office. Patients with high-dose opioids require either dose justification or plans for dose reduction to safer levels. In addition, PHC made certain non-opioid treatments available, including previously restricted medications, podiatry, chiropractic, acupuncture, and behavioral health. PHC also participates in county-initiated efforts to reduce prescription opioid use.

PHC restricts opioid availability in each new county it administers. Member assignment to a single medical office sharply curbs doctor shopping, and Oxycontin is not on the PHC formulary.

Clinicians are using the new PHC policies as a foil for their difficult discussions with patients regarding dose limitations and reductions. The policies can also be used to recommend alternative therapies. Best practices and

guidelines in opioid prescribing have become more common and uniform. This uniformity prevents the "walking with a shallow pan of water" phenomenon, in which lack of uniformity results in all the water (opioid-seeking patients) rushing to one side of the pan (looser prescribing practices).

While the PHC guidelines and restrictions have resulted in marked reductions of opioid prescriptions for PHC members, the effect on patients with other payers remains unknown.

The graphs on these pages show various aspects of prescription opioid use in PHC Medi-Cal members in Sonoma County since late 2012.

Graph 1 shows the number of opioid prescriptions per 100 PHC Medi-Cal members per month. In 2012, the number was 25.1 prescriptions per month, but it now stands at 11.71 prescriptions—more than 50% lower.

Graph 2 shows the percentage of PHC Medi-Cal opioid users on an unsafe dose (>120 MED). That percentage has also declined more than 50%, from 20.8% in 2012 to 9.5% in 2016.

Graph 3 shows the number of initial opiate fills per 100 PHC Medi-Cal members per month, which declined from 3.5 fills per month in 2013 to 2.4 fills per month in 2016. The spike in January 2014 represents the transfer of patients from the County Medical Service Program (CMSP) into PHC.

Graph 4 shows what happened to PHC Medi-Cal patients who were on a high dose 90 days prior to January 2014. Of those patients, 25.2% had a dose escalation during that month, but the percentage has since dropped to 11.2%—yet another decline greater than 50%.

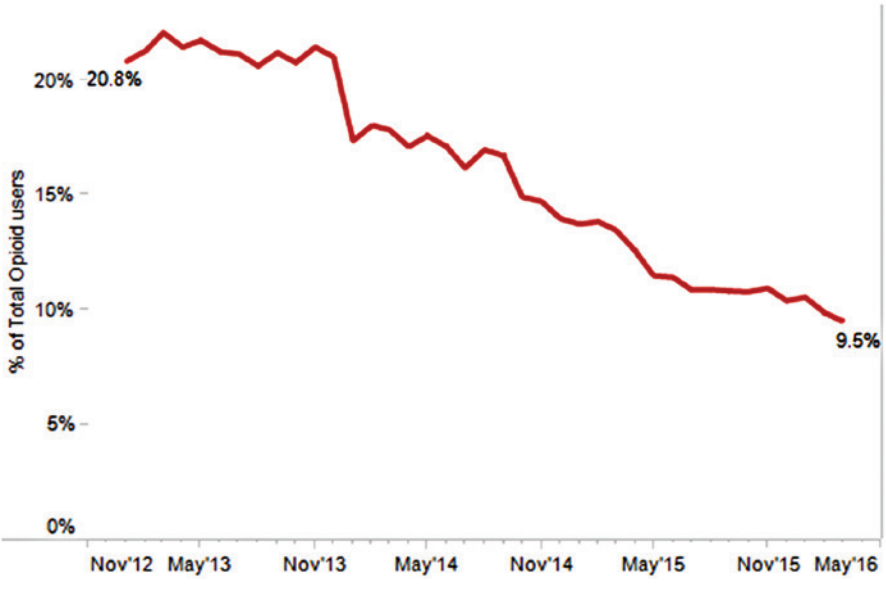
The new PHC drug policies have affected all levels of the opioid pyramid. In the heterogeneous base and middle portions of the pyramid, many patients have successfully tapered opioids to safer levels and are using other pain treatment modalities. The policies have also helped to uncover opioid dependence or diversion in these levels.

Drug overdose morbidity and mortality occur in the top level of the opioid pyramid. The rate of ED visits and hospitalizations in Sonoma County related to opioid overdose is higher than the state average. To address this problem, PHC has begun a pilot program to make naloxone more accessible as an antidote to drug overdose. Naloxone is available in IV, injectable, autoinjectable and nasally administered forms, but its availability in local pharmacies is variable.

For the pilot program, PHC has given participating providers a nasal atomizer that can be attached to preloaded naloxone injection syringes for easy nasal application. A prepackaged program has been devised to initiate naloxone use in clinics. In the Guerneville area, Dr. Jared Garrison-Jakel, Lark Pharmacy and Guerneville Safeway pharmacy have offered valuable assistance in piloting and developing the naloxone program, which is now

Graph 1. Opioid prescriptions per 100 PHC Medi-Cal members in Sonoma County, 2012–16

Graph 2. Percent of PHC Medi-Cal opioid users on unsafe dose (>120 MED) in Sonoma County, 2012–16



being expanded to other parts of the county.

PHC is also aligned with other organizations and community coalitions in efforts to increase the availability of medication-assisted therapy for drug addiction, particularly for buprenorphine therapy, which requires physician licensing. Education and financial incentives have been provided to encourage greater access to these therapies.

Overdose-related hospitalizations are being explored as well. Data from PHC utilization management records for such hospitalizations has been collected to determine the feasibility of using CURES and background prescribing data to better inform clinicians of the adverse outcomes for patients with opioid prescriptions.

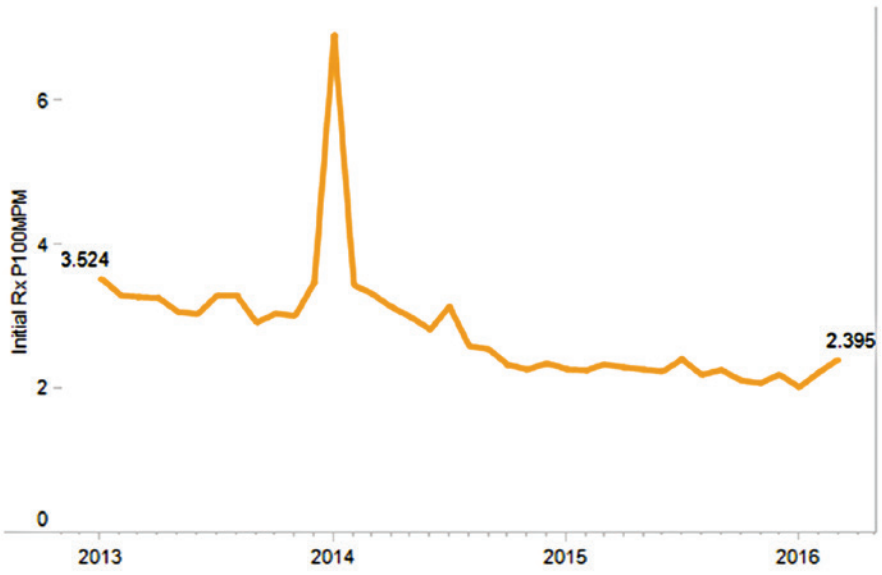
The pipeline to chronic opioid use begins with the first opioid prescription. An Express Scripts study, "A Nation in Pain," determined that nearly one-half of patients who took opiate painkillers for more than 30 days in the first year continued to use them for three years or longer.[3]

This summer, PHC will restrict initial opioid prescriptions to 30 tablets, with prior authorizations required for any extensions. Like the PHC dose-prescribing limits, this policy will be a heavy lift for clinicians, so PHC is conducting an awareness campaign for primary care offices, orthopedic surgeons, hospitalists and dentists. Future PHC policies may address co-prescription of benzodiazepines, muscle relaxants and sleep medications.

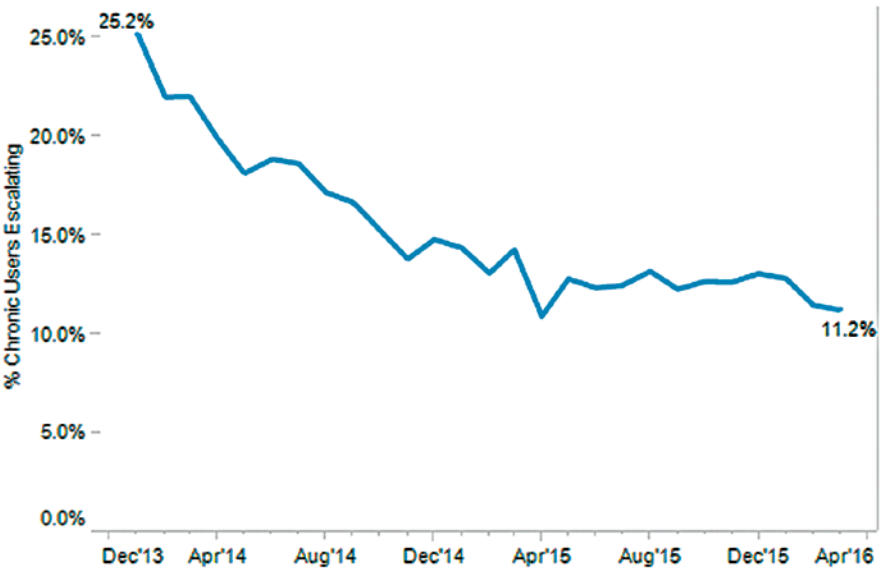
PHC is committed to improving the health of the people and communities we serve. Through a company-wide commitment to fixing the prescription opioid epidemic—and by working with members, communities, and invested organizations—PHC aims to remedy this problem while optimizing the well-being of its members and its dedicated clinicians. ◇

Email: mkubota@partnershiphp.org

Graph 3. Initial opiate fills per 100 PHC Medi-Cal members in Sonoma County, 2013–16



Graph 4. Percent of chronic PHC Medi-Cal opioid users escalating in January 2014 cohort, Sonoma County, 2014–16



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Lotus Bowl (Scott Chilcott, MD—see page 31)

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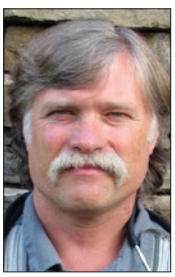
Strategies for Reducing Opioid Use

Gary Pace, MD

Earlier this year, former FDA director Dr. David Kessler said in a CBS News interview that the aggressive expansion in use of opioid pain medications "has proved to be one of the biggest mistakes in modern medicine."[1]

The problem isn't that doctors prescribing opioids are incompetent or foolish. Instead, they thought they were helping patients based on the newest research. Now that the tide has turned against prescribing opioids, physicians don't have much more to offer pain patients than they did 20 years ago, when long-acting opioids hit the scene.

New initiatives aimed at educating physicians and the public on the importance of decreasing opioid use, and of developing systems to monitor prescribing patterns, may help with the epidemic; but the initiatives employ the same strategy of the failed War on Drugs: trying to stop the supply without addressing the demand. By paying attention to the demand side—the patient perspective—we can gain a fuller understanding of opioids and learn effective strategies for reducing opioid use. Below I discuss some of the approaches that are being recommended or that we are trying at our site that can be useful when approaching patients who are struggling.



Dr. Pace, a family physician, is medical director of Alexander Valley Healthcare in Cloverdale.

Weaning

The current push for reducing opioid prescriptions involves setting policies and guidelines to get patients below 90–120 MEDs (morphine equivalent doses) per day to minimize the side effects and the risks, and to maximize the benefit. Before the paradigm shift, our clinic had problems bringing opioid dosing down. Patients would perceive us as being withholding and punitive for making them suffer when "effective" measures were available. Now with the public education campaign and the policy changes on medication coverage, most of our patients have been able to decrease their doses with relative ease.

In our experience, a relationship-based approach with a clear focus on the goal has proven most effective. Dose reduction strategies include:

- Reducing the daily dose by 5–10% every month, with some flexibility during flares or stressful times.
- Using our relationship with patients to get them interested and optimistic about the process.
- Educating patients about the long-term benefits of lower doses.

Of course, there are exceptions where patients—sometimes labeled "legacy patients"—are unable to wean. They are stuck in limbo: they know the medications are bad, but they can't tolerate reducing them. In our practice, these are often patients with psychiatric problems, substance-abuse histories, poor insight and tenuous living situations. One patient, schizophrenic and with chronic pain, mishandled a slow wean by regularly coming up short, and then not managing to navigate the prior authorization process. He ended up paying out of pocket for some of his meds, which led to financial difficulties, and he has now lost his housing. Essentially, the wean ended up being the straw that led to his destabilization.

Replacement

Buprenorphine (a mixed agonist-antagonist for opiate receptors) is gaining prominence as a first-line solution for replacing conventional opioid pain medications. It has a moderate pain-relieving effect, and because of its unique pharmacology, overuse or the need for increasing doses is generally avoided. I have worked with this medication for more than 10 years, for both pain patients and addicts, and have seen some dramatic results. Because of the drug's long half-life, its strong affinity for opioid receptors (thus blocking other opioids from having much effect), and the plateau of drug effect, cravings tend to disappear quickly.

Physicians need a special license from the DEA to prescribe buprenorphine for addiction. The license can be easily obtained by going online for several hours of specialized training. Prescribing buprenorphine for pain has no prescribing limitations separate from other opioids.

Starting buprenorphine usually involves an initial consultation, followed by an induction period. During the induction, patients stop using opioids for a certain amount of time (usually 12 hours for short-acting opioids, 24 hours for long-acting opioids,

sometimes longer for methadone), and come into the office when they are starting to go into withdrawal. The rationale for this approach is that if opioids are still in their system, the avid receptor affinity of the buprenorphine will knock the opioids off the receptors and the patient will go into a rapid withdrawal. If they are already withdrawing, the buprenorphine will help resolve their symptoms quickly.

Since buprenorphine is a combination of antagonist and agonist, it avoids the hyperalgesic effects of other opioids, so dosing goes down over time. Also, since there is a plateau of effect at about 24 mg per day, taking more buprenorphine does not lead to a "high," nor is there a risk of overdose. Buprenorphine is especially useful in early recovery, because it tends to block effects of other opioids, thus discouraging relapse.

My experience with buprenorphine has been positive in several pain patients who continually ran out of their medications early. They switched to buprenorphine and no longer come to the clinic with one crisis after another. Clearly, there was some sort of addiction component to their earlier struggles.

Non-opioid therapy

The recent CDC guideline for prescribing opioids states, "Of primary importance, non-opioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks."[2] Patients can be hard to sell on this approach, especially when insurance companies won't cover many of the strategies that seem to have some efficacy.

The research on non-opioid therapy is complicated and somewhat ambiguous. A 2007 guideline from the American College of Physicians and the American Pain Society found that cognitive-behavioral therapy, exercise, spinal manipulation and interdisciplinary rehabilitation were moderately effective for chronic or subacute low back pain.[3] The guideline also found that acupuncture, massage, yoga and functional restoration can be effective for chronic low back pain. The only non-opioid therapies with evidence of efficacy for acute low back pain were superficial heat and spinal manipulation.

My experience is that having a variety of modalities available can help selected patients, but our ability to address chronic pain with these modalities is limited. People who are motivated and empowered in their lives tend to benefit from the lifestyle-based therapies. Cognitive approaches can be particularly helpful in getting people to change their relationship with pain. Interventional and physical medicine approaches have an extensive write-up in the medical literature. Finding the right combination of these modalities seems to be specific for each patient.

Addiction

A patient recently described to me the despair he used to feel while driving to his drug dealer's house. The whole way, he knew he didn't want to go, that his life would be much worse for getting the drugs. Yet, something else had control of his body, and he couldn't stop it. He would be in tears as he turned into the driveway. Now, after years of being clean, he still worries that he could lose control and sink into addiction again.

Neuroscience research shows that addiction is a brain disease, not an issue of willpower. The brain chemistry becomes altered because of repeated exposure to addictive substances. Receiving dopamine release from the addictive drug becomes the addict's over-riding focus, and avoiding the withdrawal and the crash when there is no drug can become an obsession. Research on risk factors considers genetics, but recently there is increased attention on the effects of adverse childhood experiences (ACE). For instance, a male child with an ACE score of 6 (out of 8), when compared to a child with an ACE score of 0, has a 46-fold increase in the likelihood of becoming an injection drug user sometime later in life.[4]

When is the line crossed from legitimate use of opioids for pain relief to use for addiction? Physicians are well aware of patients who run out of pain meds early, have various excuses and consume a lot of time in the office. Ten years ago, "experts" were saying that it was unusual for people on pain medications to slide into addiction; but experience suggests a much higher risk. Moreover, as access to prescription opioids becomes limited, patients shift to cheaper, less predictable alternatives. Heroin overdose deaths have increased more than 30% annually since 2010.[5]

Opioid addiction treatment is difficult to access, and just two general models are available: abstinence-based treatments (the 12-step model) or medication-assisted treatment (MAT) with buprenorphine or at methadone treatment centers. MAT is gaining traction, and research shows that it saves lives. When Baltimore improved access to MAT in the community, drug overdoses decreased by 50%.[6] MAT patients generally have longer relapse-free periods than patients aiming for complete abstinence.[6]

Many of the opioid addicts that I have worked with over the years have had dramatic turnarounds in their lives with buprenorphine, and I encourage physicians to get trained and offer this service to the community. MAT allows them to step off the all-consuming treadmill of planning how to obtain drugs. They begin to be able to reenter society and to appreciate the joys of working, of re-engaging with family and friends, and of having some control over their lives again. One of the most touching stories I heard was of a young man who was finally able to go to his extended family's Christmas gatherings after many years of being forbidden because of the outrageous and criminal behavior he had previously exhibited.

Some unusual approaches to opioid addiction are not available in the United States. Psychoactive plants with unique properties when used in appropriate settings may have success as cures for addiction. For instance, a treatment center in Peru that uses ayahuasca, an Amazonian plant concoction, reports a cure rate greater than 50% for difficult addictions, a result that would be the envy of treatment centers in the U.S.[7]

Ibogaine, from a traditional African healing tradition, is said to help opioid addicts avoid withdrawal after one extended and rather intense treatment.[8] Since these plant-based treatments are illegal in the U.S., research is scarce, but the treatments do raise some provocative questions and avenues for inquiry.

Conclusions

Is the amount of pain that contemporary Americans claim to experience higher than what Americans experienced in earlier eras? It would be a stretch to believe that people doing physical labor in earlier times or in other cultures had less pain than we do now. The U.S. has just 5% of the world's population, but it consumes 75% of the opioid pain-killers.[9] Clearly, Americans need a cultural shift in their willingness to tolerate discomfort.

There aren't any easy answers to the prescription opioid epidemic, but a few suggestions seem obvious. My interest here is for the policy-makers and thought leaders to move from a punitive approach that limits medications to a broader approach that includes the patient perspective. We need to:

- Reduce the number of opioids prescribed; we are having some success with that.
- Develop comprehensive strategies that work with pain, including non-pharmacologic approaches such as acupuncture, chiropractic and cognitive-behavioral therapy.
- Expand addiction services and recognize the life-saving capabilities of medication-assisted treatment.
- Examine the relationship our society has with pain and suffering, and go beneath the surface of the quick fix. ◇

Email: gpace@alexandervalleyhealthcare.org

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Treating Substance Abuse in Pregnancy

Erin Lund, MD, MPH

As a family medicine resident in Santa Rosa from 2005 to 2008, I rarely saw patients with opioid dependence in pregnancy. I recall managing a handful of women on methadone during those years, but heroin use in pregnancy was unheard of. We residents cared for plenty of substance-abusing patients in our family medicine clinic, but the drugs of choice seemed to be marijuana and methamphetamine.

Times have changed. Opioid use has grown rapidly in our community, and local physicians are seeing many more opioid-dependent pregnant women.

I learned to care for pregnant patients struggling with opioid use disorder while completing an obstetrics fellowship at the University of New Mexico following residency. New Mexico has had a problem with heroin and other opioid abuse for decades. At the UNM hospital where I worked, we cared for large numbers of women who used opioids during their pregnancy. I managed these women with methadone and buprenorphine, and I treated their babies for neonatal abstinence syndrome (NAS).

Dr. Lund, a family physician, directs the New Beginnings Clinic at the Vista Family Health Center in Santa Rosa.

When I returned to Sonoma County to work at the Vista Family Health Center in 2010, I didn't expect to use my newly acquired skills for managing opioid dependence in pregnancy. During my first years in practice, however, I was surprised by the growing number of opioid-dependent pregnant women at our clinic—as many as 2–3% of our pregnant patients. Most of our opioid-dependent patients use prescription opioids obtained illegally, but recently we have seen more using heroin. Compared to during my residency, we also care for more patients who became pregnant while on methadone or buprenorphine maintenance for histories of opioid dependence.

We now care for at least 20 women annually who became pregnant while abusing opiates. We care for an even greater number who use prescription opioids given by their doctor for pain. Both populations represent high-risk pregnancies, and their babies are at risk for NAS.

During my initial years caring for opioid-dependent pregnant women at Vista, I realized that our local systems of care were not as well integrated as UNM's. I struggled to collaborate with local methadone clinics over mutual patients or new referrals; the type of care patients received at the hospital varied greatly depending on which medical providers and social workers were on call; and the patients had to cross many barriers to engage in regular prenatal care.

I also discovered that all of the local drug-treatment programs for pregnant women or women with children are abstinence-based and will not accept women on methadone or buprenorphine. The lack of a residential treatment program for opioid-dependent women in our community means that many patients ultimately cannot organize themselves enough to stay enrolled in outpatient treatment, so they return to using opioids illicitly.

Why are abstinence-based treatment programs inadequate to meet the needs of this population? Decades of research show improved outcomes for opioid-dependent pregnant women placed on methadone maintenance as opposed to encouraging abstinence. Compared to abstinence programs, the rate of illicit opioid use is greatly decreased by methadone maintenance; and prenatal care compliance, weight gain, gestational age at delivery and fetal birth weights are all improved.[1]

Opioid dependence in pregnancy is different from addiction to drugs like methamphetamine, in that the physical withdrawal state produced by chronic opioid use can have serious consequences for the pregnancy and fetus. Opioid withdrawal can lead to fetal growth restriction, preterm labor and fetal death.[2] While methamphetamine use throughout pregnancy is likely associated with growth restriction, there is

lack of good quality evidence suggesting other short- or long-term consequences.[3]

Many studies have shown the safety and efficacy of buprenorphine as an alternative to methadone maintenance in pregnancy.[4] The benefit of buprenorphine over methadone is that the symptoms of NAS associated with buprenorphine seem to be milder and require less extensive treatment than NAS symptoms associated with methadone.

The American Congress of Obstetricians and Gynecologists recommends either methadone or buprenorphine maintenance for treatment of opioid use disorder in pregnancy and strongly discourages withdrawal or tapering due to the risks mentioned above.[5] All things considered, either methadone or buprenorphine are preferred to abstinence-oriented programs, particularly given the improved pregnancy outcomes compared to withdrawal from opioids.

In 2015 I founded the New Beginnings Clinic at Vista to better care for the highest risk pregnant patients at our clinic. In my five years of practice prior to that I had seen the many ways in which our usual system of care was inadequately serving substance-abusing pregnant women. Under the old system, substance-abusing women were frequently assigned to one of our family medicine resident physicians in early pregnancy. The resident would screen the patient, learn of her drug use and then consult me for advice with managing her pregnancy. We would outline a management plan prior to her next visit, but frequently she would miss that visit and get rescheduled with another resident or staff physician. That physician would contact me for advice after the visit, only to have the same thing happen again.

I realized that it was inappropriate for our least experienced physicians to manage our highest-risk patients. Moreover, unless we addressed our patients' multiple barriers to accessing care (e.g., unstable housing, poor transportation, active drug use, fear of losing their baby), we would struggle to provide even basic prenatal care for these women.

My vision for the New Beginnings Clinic was to offer wrap-around services during all OB visits, including case management, behavioral health counseling and pregnancy education. The OB visits would always be with myself or with Dr. Joe Matel, another family physician who completed his obstetrical fellowship at UNM and is comfortable treating this patient population. Our goal in the clinic is to work as a team (nurse, social worker and physician) to facilitate patient enrollment in drug treatment as early in pregnancy as possible while supporting her efforts to sustain major life changes and prepare for motherhood. We also follow women and their babies postpartum to ensure that they remain stable through the challenging first months after giving birth, a time when relapse is common.

The New Beginnings Clinic has been quite successful. For patients seeking help for their drug use in pregnancy, we offer a supportive, non-judgmental team of providers who help them become drug-free. For women who are ambivalent about their substance abuse, we help them understand the long-term consequences of ongoing drug use for their own health, their baby's health and their future ability to parent. While we can't reach every patient, most of those who stick with us are ultimately able to get and stay clean by the time they deliver.

Having a nurse actively case-manage each patient saves time and helps us provide better care for more patients. The presence of a case manager improves our collaboration with other providers, such as local treatment programs, the jail, the Smoke Free and Drug Free Babies programs, public health nursing, and hospital social workers. Our behavioral health provider meets with each patient to address the trauma and co-morbid mental health disorders common to this population.

The clinic is held every Tuesday afternoon at Vista. We typically schedule 15–18 patients and see 12–13 who actually show up. We try to get patients who miss their appointments in the following week, sometimes by offering bus passes or taxi vouchers. When we can't reach patients by phone, we collaborate with public health nurses to locate these patients and encourage them to come in.

We see most of our patients every two weeks throughout their pregnancy, which allows adequate time to manage their many high-risk social and medical conditions. Another benefit of frequent visits is that if a patient misses an appointment, we can usually get her back within the next 1–2 weeks and limit major gaps in her care. This model has worked well, and our patient volume has grown. This August we plan to increase our capacity by adding another physician and nurse to the weekly clinic.

In addition to caring for women with active or recent substance abuse, we also manage patients with other conditions that place them at high risk for Child Protective Services intervention at delivery. These patients include incarcerated women, women with severe mental illness and women in active domestic violence situations. We offer these women mental health services at the same time as their obstetric appointments.

Some limitations to the New Beginnings clinic remain. We struggle to get patients to visit the clinic for postpartum contraception when their newborn has been placed into foster care. Often these are our most complicated patients with ongoing substance use and/or severe mental illness. We want to give these patients effective long-acting reversible contraception (LARC); but once the motivation of getting healthy for the pregnancy is gone, these women frequently slip back into their old habits. We need to improve access to LARC on labor and delivery to help prevent future unplanned pregnancies in our highest risk patients. Lack of inpatient insurance coverage for IUD or implant devices is a barrier to providing these services at the hospital.

Another limitation to New Beginnings has been the lack of time in our

schedule to follow up with newborns during their first year of life. Once we expand access to the clinic, we hope to do a better job of tracking and monitoring these kids beyond the first month of life. We want to ensure that they receive adequate well-child care, including immunizations, and are also closely monitored for developmental issues and referred early if any delays are identified. We keep a manually updated list of all of our patients and outcomes, but we hope to develop a way of using our electronic medical record to track patients and their children over time.

Dr. Matel and I feel that our collaborative care model improves quality of care for opioid-dependent pregnant women and women with other high-risk psychosocial conditions. While our family medicine residents used to be challenged and frustrated by this patient population, they now work alongside us in New Beginnings and can see how rewarding caring for this population can be when you have the right resources and tools in place. While there can be many challenges caring for patients with active substance use disorders, we approach them with compassion, recognizing that none of them truly chose to live a life addicted to drugs. With an improved system of care, we can help these women turn their lives around for themselves and their babies. ◇

Email: erinl@srhealthcenters.org

The New Beginnings Clinic welcomes referrals for high-risk pregnant patients. To refer these patients, call our case manager, Susan Dunlop, RN, at 707-303-3600, Ext. 3406.

Raku Vase
(Jeff Sugarman, MD—see page 31)

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Considering a residential treatment or outdoor program?

Collaborating with referring professionals, Bob Casanova, Psy.D. is a nationally respected educational consultant who specializes in providing recommendations for students with special needs of an emotional, behavioral or psychological nature.

Bob travels extensively throughout the year and has personally toured over two hundred schools and programs. As a Licensed Marriage and Family Therapist, Bob credits his clinical training and experience in deepening his understanding of a student's needs. Bob helps students and families dealing with issues such as:

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- Drug or alcohol abuse
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- School failure or refusal
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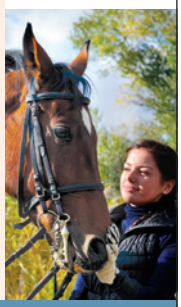
- Oppositional and defiant
- PTSD / trauma
- Autistic spectrum/NLD
- Low self esteem
- Adoption/ attachment issues
- Family conflict
- Loss and grief
- Divorce
- Learning differences



Bob Casanova, Psy.D.
Educational Consultant
Licensed Marriage & Family Therapist
License Number: LMFT 37137
707-544-7000

1260 North Dutton Ave.
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Questions? Contact Rachel Pandolfi at 707-525-4375 or rachel@scma.org.

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Open Letter to My Colleagues

Bo Greaves, MD

Twenty-six years ago, I graduated from the family practice residency at Community Hospital and started a wonderful career in family medicine in Sonoma County. A few months ago, I retired. Not a long career, but I got a late start.

During my 26 years in practice, I experienced several pendulum swings. Hormone replacement therapy was the first. Physicians went from a universal recommendation that virtually all women should receive HRT as soon as possible after menopause to an equally universal recommendation against the use of HRT. The pendulum swing began with evidence proving that HRT therapy was doing more harm than good.

Another major pendulum swing—this one against opioid prescribing for chronic non-cancer pain—is still happening, and I fear the consequences of it swinging too far back to the way opioid prescribing used to be.

In the 1980s and 90s, we realized that chronic, debilitating pain for many of our patients was not being addressed. The reasons were varied. We had too few tools in our toolbox. We were fearful of causing addiction and of being censured or punished by the Medical Board of California.

The 1990s saw a major effort to allay those fears. We came to understand more about addiction as a neurobiological condition with genetic, social and environmental factors. Addiction is characterized by continued obsessive use of certain substances, despite significant harm to the user. The addict has impaired control over the use of the substance. We learned that not all people prescribed opioid medications become addicted. In reality, only a very small percentage do, and there are screening tools to identify them.

Dr. Greaves, a family physician, recently retired as medical director of the Vista Family Health Center in Santa Rosa.

In 1994, the Medical Board of California adopted guidelines stressing the obligation of physicians to treat pain, and to do so responsibly. But the resulting pendulum swing toward allowing more opioid prescriptions has swung too far. We thought that we should have no upper limit on opioid dosage. We were not good at getting people off pain meds. Within our chronic pain population, we were not screening for signs of addiction, nor for diversion. We were not routinely using urine drug testing, and there was no CURES system.

Despite these shortcomings, we did help a lot of patients. The growing number of pain specialists, together with primary care physicians, started doing a better job of relieving pain, suffering and disability for patients with severe neuropathic pain. Many patients were able to function again, and to work and care for themselves and their families.

Up until recently, the notion of prescribing more opioid medications was widely adopted; yet the selection of patients for these powerful and dangerous meds was not based on strict criteria. Too many patients slipped from treatment of acute nociceptive pain to chronic ongoing opioid treatment. New, more potent, and longer-acting opioids were developed and aggressively promoted by big pharma. We were much better at increasing opioid dosage strength than at tapering patients off the drugs.

It is important to remember that this pendulum swing toward more opioid prescriptions developed from one of the noblest and most ancient impulses of our profession: to relieve suffering. Despite all the shortcomings, my perception remains that my chronic pain patients benefitted during that pendulum swing. They felt better and they functioned better.

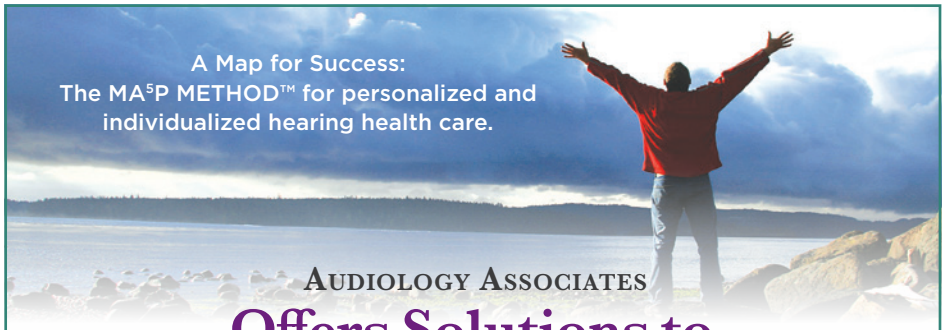
But we underestimated the high risks of these medications. Too many patients continued to receive opioids when the medications should have been reduced and stopped. Many patients were on what turned out to be dangerously high doses. Opioid prescriptions became a major public health issue, and overdose from opioid medications became the No. 1 cause of injury deaths in the United States.

There is another age-old obligation our profession has: to do no harm. It is difficult to weigh risks against benefits when you are underestimating the risk side of the equation.

So the pendulum is swinging back, with a comprehensive, systems approach to reducing the risk to our patients and the diversion of these dangerous meds to others in the community. The components of this approach are described elsewhere in this issue of *Sonoma Medicine*. They

include making a thorough assessment of the cause of pain, assessing risk for addiction and abuse, and taking concrete steps to prevent diversion of medication to others. Regular urine testing and CURES reports are essential. At the heart of this approach is engaging the patient in weighing the risks of treatment against the possible benefits, and working together to provide the best functional outcome at the lowest possible risk.

Government and community agencies are also taking action. In 2014, the MBC published revised guidelines for prescribing controlled substances.[1] An opioid work group in Sonoma County, one of many similar coalitions throughout California, has developed safe prescribing guidelines for local physicians to implement. These guidelines, known as "Safe Management of Chronic, Non-Cancer Pain," are based on existing national, state and county guidelines.



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I agree with all of these steps. Reducing risk and preventing harmful diversion are key to addressing the current public health crisis. Vista Family Health Center, where I ended my career, started implementing the key elements of this systems approach several years ago.

A pendulum swings until it reaches its extreme, until unintended consequences become apparent and cause the pendulum to swing back in the other direction. We are, I believe, at risk for serious negative consequences stemming from the noble desire to reduce risk of death from opioid medications.

There is a growing "opinion" that opioid medications are almost never appropriate for the treatment of chronic neuropathic pain. This negative view of opioids has become a bandwagon. Both *Time* and *Consumer Reports* have published cover stories that articulate the negative view of opioids, even though there isn't, to my knowledge, any high-grade evidence to support that opinion. We all have patients who have done well without opioids, and others have done as well, or better, after getting off their chronic opioid medications. We also have patients with clearly worse functional outcomes when they stop their opioid medications. There is widespread anecdotal evidence on both sides. Until there is a rigorous, evidence-based answer, it is dangerous to state an opinion as a fact.

I spent most of last year helping my small patient panel find new family doctors as I prepared to retire. I had a registry of about 80 patients with chronic pain who were on regular opioid meds. Those who stayed at Vista Family Health Center, where we had developed a clinic-wide approach to pain management, had a good transition. Those who transitioned into community practices universally reported back to me that they liked their new family doctor, but the new doctor handled their chronic pain by saying, "I don't do that," and referring them to a pain specialist. It saddens me that the promise of family medicine, to treat the whole person, isn't

being fulfilled when it comes to treating pain.

We appear to be returning to the era of physicians' fear of turning patients into addicts, and of getting into trouble by prescribing pain medications. This fear may lead to significantly undertreating the pain and suffering of our patients.

Perhaps most important, the current climate undermines the most valuable thing that we offer to patients in primary care: a relationship of trust. If we create an atmosphere based on distrust, where people who are seeking to live as full a life as possible in the face of severe pain are made to feel like addicts, we undermine the value we have to offer.

We should remember that, especially in the area of opioid treatment for chronic pain, our own biases and experience can color our opinion and approach. I am no exception. In 1999, when I was chief medical officer for the St. Joseph Health Foundation, I had a herniated disc with severe sciatica. For four months I continued to work, standing at meetings and at my computer. I was up from 1 to 4 a.m. almost every night, pacing and trying to reduce the sciatic pain. During those months, I took hydrocodone 2–4 times a day: without that, I would not have been able to work or do much of anything else.

I did physical therapy. I had two epidural steroid injections. The first helped a little, but the second made the pain much worse. Three days later, after spending an entire night draped over a beanbag chair, I was admitted to the hospital and had surgery that evening. Miraculously, I awoke with no leg pain!

I still have back pain every day. I can usually manage with naproxen, and I occasionally have to take hydrocodone; but the horrible sciatic pain has never returned. To this day, I wonder what would have happened if my surgery had failed. What if there was no surgical option, and I had to live with the sciatic pain? If opioid medications were part of a treatment plan that allowed me to continue my career and be there for my family, I would have welcomed them. Why should we think that our patients, in the same situation, deserve anything less?

I believe that we can settle on a middle ground and avoid being swung too far by this pendulum. Primary care physicians can be cautious and implement guidelines that will reduce risk and prevent diversion. At the same time, these physicians can be compassionate and empathic and use all reasonable treatments to alleviate pain and increase patients' quality of life. For the sake of our collective patients (our community), and for the enhancement of strong relationships between primary care physicians and their patients (which is the source of our joy), I sincerely hope we can get there. ◇

Email: bo.greaves@gmail.com

References

1. Medical Board of California, "Guidelines for prescribing controlled substances for pain," www.mbc.ca.gov (2014).

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- Serve on an SCMA or CMA committee, or be a legislative advocate.
- Communicate with a legislator about a health-related issue.
- Participate in surveys or vote in the annual election.
- Nominate a colleague for a physician award.
- Attend SCMA dinner and receptions, CMA Leadership Academy or House of Delegates.
- Volunteer your medical services at free clinics or health fairs.
- Notify SCMA of any engagement with SCMA, CMA and/or community activity. *(Submit brief description, date, number of hours, and location to SCMA.)*

For more details, contact Rachel Pandolfi at rachel@scma.org or 707-525-4375.

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SCMA President Regina Sullivan, MD

Steve Osborn

Born in Africa, Dr. Regina Sullivan spent much of her youth in Zurich, Switzerland, where she graduated from high school at the American International School of Zurich. She attended college in the United States, earning a BA in chemistry from the College of Wooster in Wooster, Ohio. While working as a chemist with the EPA, she pursued a graduate degree in chemistry at Rutgers University in New Jersey. In 1990, she began medical school at the University of Medicine and Dentistry, New Jersey Medical School, graduating in 1994. She completed her residency in obstetrics and gynecology in 1998 at Brookdale University Hospital and Medical Center in Brooklyn, New York.

From 1998 to 2008, Dr. Sullivan ran a busy solo ob-gyn practice in the Lehigh Valley. She also served as a clinical instructor at Warren Hospital and Sacred Heart Hospital family practice residencies, and as president of the Warren County Medical Society. In 2006, Dr. Sullivan earned her MBA from the Isenberg School of Management, University of Massachusetts at Amherst. She is a CPE (certified physician executive) from the American Association for Physician Leadership.

Dr. Sullivan joined Kaiser Permanente Santa Rosa Medical Center in 2008. She is currently the medical director of Maternal Child Health Services at the medical center, with additional responsibilities as a communications consultant and service on several committees, including Physician Health and Wellness. She and her husband, Tim, and their two teenage children, Brendan and Tara, reside in Santa Rosa.

Mr. Osborn edits Sonoma Medicine.

The following interview was conducted in Dr. Sullivan's office on April 26.

Why did you decide to become a doctor?

I looked towards medicine at a very early age. I had an uncle who trained at Cambridge in internal medicine, and an aunt who was a midwife and practiced homeopathic medicine. I remember people saying my aunt could turn the baby, which in OB we call external cephalic version. So that was fascinating to me. My uncle trained in modern medicine with all the technology, and my aunt used herbs and homeopathic medicine. I thought wow, this is great, because they were both practicing medicine and helping people, but from very opposite ends of the spectrum. Travelling through China and Tibet in 2006 with the American College of Physician Executives, I saw a similar phenomenon. The hospitals in the urban centers were modern, fairly well equipped, but the rural hospitals were very different. Still doctors practice there and help patients every day.

When did you decide to specialize in ob-gyn?

Late. I imagined I was going to be a pediatrician because I loved kids. However, during my pediatric rotation I was caring for some very sick children. Seeing children in crisis with diseases like sickle cell, HIV, cancer and leukemia was too emotionally draining on me to be an effective caregiver to these very deserving children. So I thought, okay, what am I going to do?

Following pediatrics, I began my OB rotation. It just seemed a perfect fit. I loved the surgical aspect, I could counsel my patients in the office and I could deliver babies, which touched on the pediatric aspect as well. For me, that was great. I tried to talk myself out of it! That's why I said *late*, because as much as I loved and enjoyed ob-gyn, looking at the rotation, I knew it meant a lot of hours and it was intense: but the fit for me was perfect, and I have never regretted that decision.

Where did you practice after you finished your ob-gyn residency?

I joined a solo practitioner in New Jersey in practice for 25 years. The plan was that I was going to join him and in five years he was going to retire. But after barely two years he retired to Florida. He was from a time when HMOs were just starting. He had a practice in what people say were the good old days of medicine. His perception was that he didn't go into medicine to call somebody every time he needed to do a procedure or patients needed something that an HMO had to give certification for. He retired, and for close to ten years I was the owner, the CEO and the president of the practice. I hired a midwife, but pretty much I was a solo practitioner.

Did you come to Kaiser Santa Rosa from there?

Yes. I covered several thousand women patients in three hospitals, and as my practice grew, the work was getting a lot more demanding. I knew I needed

a change. I began looking, and when I came to Kaiser Permanente in Santa Rosa, I absolutely fell in love with the people, the hospital, and the area—it's the greatest place on earth! I liked Kaiser's model where I could practice medicine without thinking about the cost, in a way the cost is indirect.

When I was a solo practitioner, I would see my patient and order tests, such as a mammogram, only to have the insurer deny or delay and make you jump through hoops to be reimbursed. Here at Kaiser Permanente, I can spend time with my patients, listening to their concerns and addressing their medical needs. The down side of course is we sometimes forget that truly there is a cost to the practice of medicine.

How would you describe your patient population here?

Our patient population is mixed, but in general they are healthy. One trend that we are seeing affects not just Kaiser Permanente, but also the entire country. It's the increase in obesity, the increase in high BMIs. Obesity brings a higher risk of hypertensive disorders, a higher risk of diabetes. It has an impact on all facets of a woman's care. We need to work towards getting women healthier.

What other kinds of problems do you see among pregnant women?

Marijuana. People think of marijuana as not being a drug, but I have to counsel my pregnant women that marijuana does have an impact. Marijuana is a drug just like tobacco. We tend to see a higher population of women who admit that they have used marijuana. I have not encountered that much in terms of cocaine or heroin or other hard-core drugs.

What are the consequences of marijuana use in pregnancy?

I counsel my pregnant patients against the use of marijuana during pregnancy. The perception is that marijuana is not harmful. However, marijuana is a drug with potential adverse effects, especially in pregnancy. For example, it causes less oxygen and food to get to the baby, making it more difficult for the baby to grow. It affects the baby's brain development and can cause serious behavioral problems.

One enduring controversy in ob-gyn is the percentage of cesarean births. What do you think the balance should be?

Maternal and fetal safety is always and will always be the number one priority. So when I am on call in labor and delivery, I have two patients: I have the patient, and I have her baby. That is the basic tenet. It is true that when you look at the data from the 1990s up to 2011, this country had a high rate of C-section. It was more than 30 percent. After 2011, the rate plateaued. And then ACOG *[American College of Obstetrics and Gynecology]* took an active role to bring the rate of C-section down. They are trying to reduce the rate to 25 percent or less.

As the medical director of maternal child health services, I feel confident that my colleagues are using evidence-based and team-based care. If a C-section is needed for either maternal safety or fetal safety, the metrics will follow. Quality of care is paramount. Yes, we do follow ACOG guidelines and standard of care; keeping maternal and child health and safety will always be our top priority.

What is your take on home births? Does Kaiser allow that?

I follow ACOG guidelines. ACOG believes that the safest place for a birth is in a hospital or birthing center, but they respect a patient's right to make informed decisions about where she wishes to give birth.

If a Kaiser Permanente patient wishes a home birth, there needs to be a dialogue between the physician and the patient. The patient needs informed consent about the potential risks involved. There should be a hospital close by if a transfer becomes necessary. That is what the discussion must entail. Essentially, make sure there is a backup plan in case things do not go smoothly. I respect my patient's wishes after having informed consent.

Two big changes in medicine have been implementation of the Affordable Care Act and consolidation of hospitals and physician groups. Do you think these changes have actually benefited patients?

The metrics are still out there as far as the ACA is concerned. The intent of the ACA was to do as much as possible to help patients access medical care. Compared to a few years ago, there are more patients who are able to get health care, so that is good. The consolidation of hospitals and physician groups is more market-driven than anything else. How do you change the model to absorb the patient volume out there?

Has your own practice been affected by the ACA?

Yes. Kaiser Permanente predicted a certain percentage of increase in patient volume, but we're seeing more patients than what was predicted. We have hired up and are hiring more physicians and staff. Luckily, we have a robust integrated electronic medical system and the necessary infrastructure in place to help us absorb the increase. When I see a new patient, even though I am seeing her for an obstetric reason, I obtain her complete medical history. I can order the labs if needed. If she needs to see a general surgeon today, I can do that. If I feel a mass in her breast and I want her to get a mammogram, I can do that. I can capture that patient's history today and do the best for her, and that is a great thing. I am seeing people who have not seen a doctor for many years. I am happy that I can see them, and I do all I can.

What challenges do your patients have with staying healthy?

I counsel my patients about eating healthy. Yet reality is different from the ideal. Take, for example, a single mother of four with a meager budget who goes food shopping. She can spend nearly five dollars for a loaf of nutritionally balanced multi-grain bread, or 99 cents for a large loaf of white bread whose ingredients include high fructose corn syrup. Her kids being hungry will drive her buying decision more than anything I say about healthy eating and exercise. If my patient is working two or three

Dr. Sullivan in her office at Kaiser Permanente Santa Rosa Medical Center.

jobs to make ends meet, if she has to feed those kids with a limited amount of resources, the balance is off. We can only do so much.

Why is membership in SCMA and other medical societies declining?

I think it is a combination of factors. One is the increased volume of patients. Medical offices are getting busier, so where is the time for participation? Another factor is the cost of membership and the perceived benefits. What is SCMA doing for me? What is CMA doing for me?

How do we address each of those concerns? How do I say to my colleagues out there that SCMA and CMA are helping them? One physician cannot go to the Capitol or the White House to make a significant change. Change needs a unified voice, and it takes time. Physicians need to step up and be the leaders and get more involved with making change.

It doesn't matter if you are an allergist, an anesthesiologist, a family physician, or any other specialty. We all have a common thread: patient health. We went into medicine because of that passion to help. We have to remember that. By being involved together, we can start making changes that will benefit our patients, and we'll say, "Yes, that's why I went into medicine."

Have any cases in your medical career been particularly memorable?

When I was first starting, I thought, "Oh my God! Triplets!" I was excited. Now triplets are more of a big deal to their parents. Every day I am humbled about how much trust patients have in us. There are some days where I am working 24 hours straight. Yet when I go in just to touch base with a patient, somebody smiles and says thank you for being there. Each of those encounters is about listening and trusting. I am thankful for that, in fact I think I have the greatest job in the world!

Every patient encounter is memorable and special. Two recent cases—the first was very sad, a seven-months pregnant patient who we knew was coming in with fetal demise. In the midst of that couple's sadness, after I delivered the baby, the couple turned to me and said thank you. The human spirit is astounding. Can you fathom the grief of the couple at that time and yet they reached inside themselves to thank someone—incredible!

In contrast, I recently had a non-urgent office visit with a patient I had seen a year earlier. I counsel my patients about nutrition and about exercise, and if they smoke, about quitting smoking. I tend to respect a patient's wishes, to better understand why they are engaging in certain behaviors. I actually had forgotten that I had talked to her about smoking. When I saw her back she said, "Thank you." I said, "For what?" She said, "I quit smoking." Of course I got all excited and said, "Oh my God, great! Congratulations!" She said, "Do you know why?" She was a long-term smoking patient, so I said, "Okay, tell me." She said, "Because you did not make me feel bad for smoking. You were not heavy-handed."

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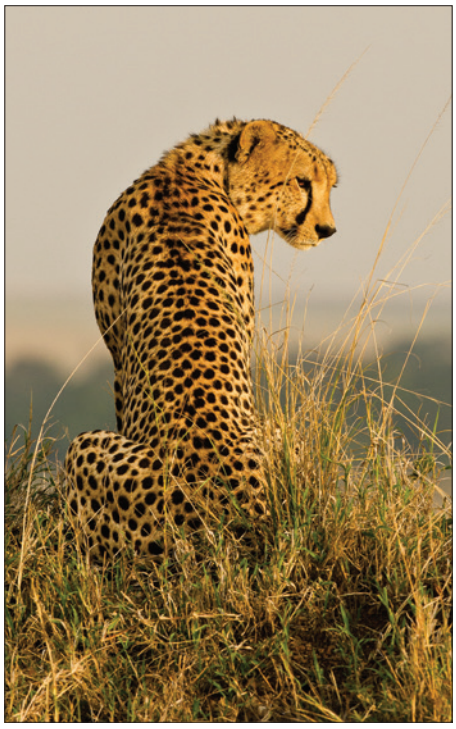
What that brought home to me is that what we say does matter. No matter the challenges, it does matter what I say to my patients. If I am tired, suffering from lack of sleep, or days with too few hours, when I walk in, it does matter what I say to my patient.

Do you have any closing thoughts?

I'd like to come back to organized medicine. Part of the reason the American Association for Physician Leadership exists is that we strongly need physician leaders. We need to make the important health care decisions in partnership with our patients. Of course there are time and financial pressures that need to be resolved, but we understand the work. This is not a new story.

Medicine is not just an awesome career, it is a passion for most of us. I think we need to dial back to that joy, to that energy, to that passion. There are challenges ahead, but we have the resilience to meet those challenges. We need to work together. It doesn't matter what specialty. It's medicine. It's patient care. It's patient safety. To be able to effect change, we need to be there. ◇

Email: regina.t.sullivan@kp.org



Cheetah in the Masa Sunset, Kenya
(Albert Peng, MD)

Hidden Talents Showcase

Artistic talents came out of hiding during the SCMA Alliance Foundation's *Hidden Talents* art show at Paradise Ridge Winery on May 5. Almost 100 works of art were on display, including paintings, photographs, sculptures, ceramics and woodwork. More than 30 local physicians and their spouses or partners submitted work for the show, which raised $5,000 for Alliance charities, such as health careers scholarships and the Give-a-Gift program for foster children.

About half the money raised came from sales of artwork; the other half came from a raffle for donated artwork and other prizes. Dr. James Kahn won a fused glass platter by Dr. Kate Black, and Pat Davis took home a painting by famed local artist Bob Nugent.

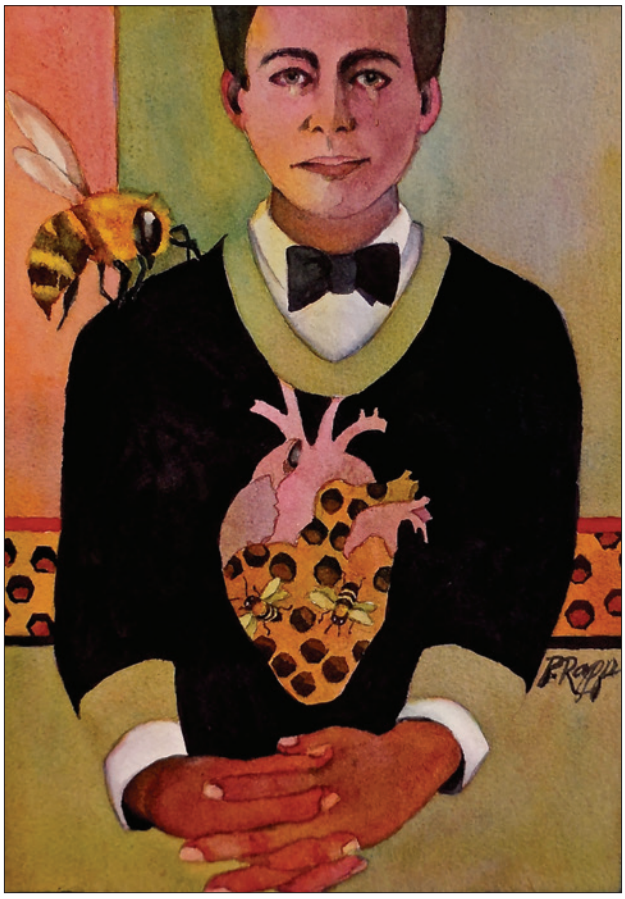
Nearly 150 people attended the show, which was deemed a huge success. Organizers hope to repeat the show with new works of art in the next couple of years.

Reproduction of selected works from the show appear throughout this issue. ◇

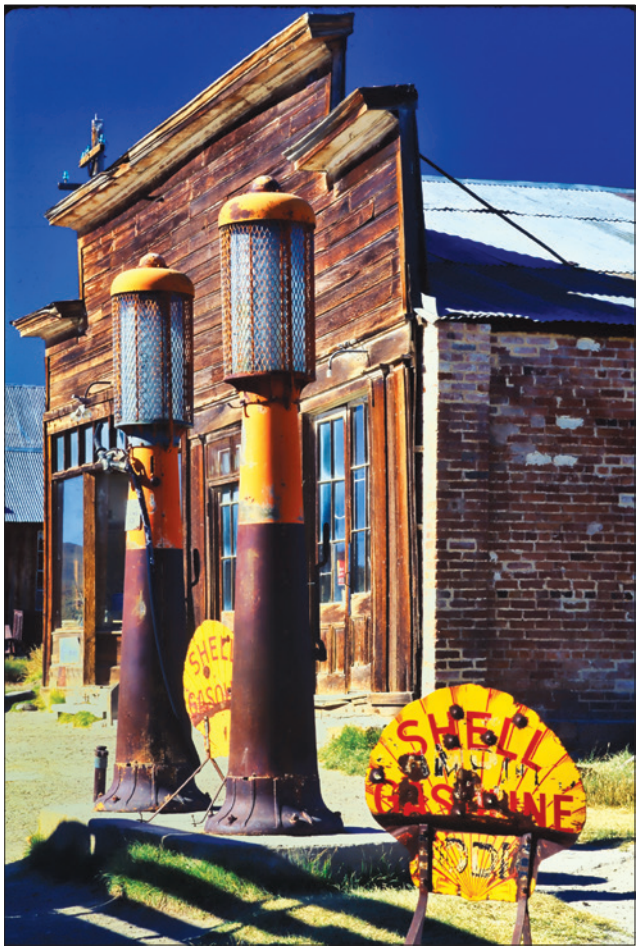
Reflection (Cat Kaufman)

Mist After the Storm (Philip Wilkinson, MD)

Snake Dance (Kate Black, MD)



Making Sweet Honey from Past Sorrows (Phyllis Rapp)



Gas Pump (Leland Davis, MD)

Dusk (Sandra Rubin, MD)

View #1 from Big River Beach, Mendocino (Louisa King Fraser)

Early Morning on Riebli Road (Karen Field)

Liquid Sky (Cecile Keefe)

Marshall Pass, Colorado, Sept. 2015 (Barry Smith, MD)

Danse (Robert Baron, MD)

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HIPAA Compliance Toolkit *Various discounts*	**PrivaPlan Associates, Inc.** 877-218-7707 • www.privaplan.com
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May 2016

Finding Hope on Mendocino Avenue

Stephen Gospe, MD, and Adam Brown, JD

Michael Hughes (not his real name) returned from his tour in Afghanistan a different person than when he left Sonoma County. He was a decorated war veteran diagnosed with post-traumatic stress disorder from the many life-changing events he'd seen and experienced during his tour of duty. After his return, his PTSD culminated in incidents of rage focused on those who, while they had the ability to help him, chose not to.

Such was the case when Michael visited the Social Security office in Santa Rosa. He had brought all the appropriate documentation, including letters from the Veterans Administration indicating he was 100% disabled from his PTSD, along with letters from physicians and independent consultants saying Michael's condition qualified him for benefits. He brought everything he was told he needed to qualify for the benefits he deserved.

Despite all that, Michael was turned down for Social Security disability benefits, just as 60% of those who apply are.[1]

Michael's PTSD-induced rage got the better of him, to the point where a Social Security clerk told him that any time he returned to their offices, for whatever reason, he would have to be accompanied by a sheriff's deputy to ensure office safety.

Frustrated, Michael didn't know what to do or where to go, until his physician referred him to the Disability Services & Legal Center (DSLC) in Santa Rosa, where he obtained free advice from attorneys who specialize in securing benefits.

Michael's story is not unusual among the people with disabilities who come to DSLC for its weekly orientation and intake session at 1:30 on Monday afternoons. During the session, Michael spoke with an attorney and received the advice he needed to appeal his negative decision. With the DSLC attorney, a case file was opened, and a hearing scheduled to get his case before the administrative law judge at the Office of Disability, Adjudication and Review. Should that appeal be denied, he can take his case to the Appeals Court in Virginia via briefs. Finally, should that case be denied, the court of last resort is the U.S. District Court in San Francisco. Michael's case is still pending.

Since 1976, DSLC has been the primary organization helping disabled people address the challenges they face every day in Sonoma, Napa, Lake and Mendocino counties. Headquartered in Santa Rosa (with offices in Napa and Ukiah), DSLC is a nonprofit agency serving more than 2,000 people annually on a wide range of disability issues.

One of the myths of being disabled is that disability only happens to people who have reached a certain age. That's not true. Disabilities cut across all ages, all races, all sexes. According to the U.S. Census Bureau, 18.6% of Americans are disabled, making people with disabilities one of the largest minority groups in America today.[2] In the four North Bay counties served by DSLC, 20% of all residents are legally disabled.[3] A disability is defined as any type of condition that inhibits a person from leading a normal, active, functional life. However, many disabilities are hidden and can't be seen by the naked eye. Here's a *partial* list of what is considered a disability under current law: autism spectrum disorder, allergies, amputation, alcoholism, ADHD, anxiety, back injuries, bipolar disorder, brain injury, chronic illness, cancer, Charcot-Marie-Tooth disease, cerebral palsy, chronic fatigue syndrome, cystic fibrosis, depression, diabetes, Down syndrome, epilepsy, hearing loss and deafness,

Dr. Gospe is treasurer and Mr. Brown is executive director of the Disability Services & Legal Center in Santa Rosa.

heart disorders, intellectual disability, memory loss, mental illness, PTSD, speech and/or language disorders, Tourette syndrome, stroke, and vision loss/blindness.[4]

Various Internet resources are available to help you decide if a patient has a disability. The Job Accommodation Network website, for example, features a useful article titled "How to determine whether a person has a disability under the ADA."[5] These resources can help you ascertain the nature of the specific disability and determine what Searchable Online Accommodation Resources (SOAR) have to be provided to the patient and/or what modifications have to be made to their home.

Here are the 10 most common ADA-related disabilities by category and percentage:[6]

Back or spinal injuries (19.1%). This is the most reported disability.

Psychiatric/mental impairments (11.7%). Includes depression, anxiety, phobias, PTSD and bipolar disorder.

Neurological impairments (11.7%). Includes migraine headaches, multiple sclerosis, epilepsy and Parkinson's disease.

Impairment of the extremities (8.1%). Includes patients with long-term damage to one or more extremities resulting from an accident or illness.

Cardiovascular impairments (4%). Includes any type of heart disease or cardiovascular system impairment.

Substance abuse (3.5%). Almost 10% of Americans engage in substance abuse, yet only 3.5% of all disability claims are attributable to drugs, alcohol, tobacco or other addictive substances.[7]

Diabetes (3.5%). Again, about 10% of Americans have either Type 1 or Type 2 diabetes, but diabetes represents only 3.5% of disabilities claimed under the ADA.[8]

Hearing impairments (3%). Includes people who are hard of hearing, deaf or have an intolerance for loud noises.

Vision impairments (2.8%). Includes people who are blind, see with only one eye or have limited vision.

Blood disorder impairments (2.6%). Includes hepatitis, anemia, lymphoma and leukemia.

What exactly is a disability? The term is amorphous, and there are many definitions. The U.S. Department of Justice (DOJ), for example, defines a person with disabilities categorically, that is, as that disability relates to employment, housing or other factors.[9] The DOJ is closely aligned with the medical profession in its interpretation of the ADA. The DOJ website indicates how a "public accommodation," such as a physician's office, should deal with a disabled person:

> The ADA does not require modifications that would fundamentally alter the nature of the services provided by the public accommodation. For example, it would not be discriminatory for a physician specialist who treats only burn patients to refer a deaf individual to another physician for treatment of a broken limb or respiratory ailment. To require a physician to accept patients outside of his or her specialty would fundamentally alter the nature of the medical practice.[9]

In contrast, the Equal Employment Opportunity Commission has a much narrower definition of disability. According to the EEOC, a person with a disability:

- has a physical or mental impairment that substantially limits one or more major life activities
- has a record of such impairment
- is regarded as having such an impairment.[10]

These competing definitions mean that each case must be looked at individually to ensure it meets all federal requirements. That's where DSLC can help.

Physicians are healers and problem solvers, not litigators. Disabled patients who are denied Social Security, Medicare or Medi-Cal claims can be referred to DSLC. The phone for the local DSLC office is 707-528-2745, and it's open during normal business hours.

Patients can also attend the weekly orientation and intake session, which begins at 1:30 p.m. on Mondays at the

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We're looking for Gardens for next year's Medical Alliance Garden Tour
Help us make this 25th Anniversary Tour the best yet!
If you know of a garden that could be featured on the tour, contact us at alliance@scma.org.
Sonoma County Medical Association Alliance Foundation
connecting medical families . . . building healthy communities

DSLC office at 521 Mendocino Ave. in downtown Santa Rosa.

At DSLC, adults, children, seniors, veterans and their families with any type of disability are eligible to receive help, free of charge, plus:

- If clients are fortunate enough to have a home and meet certain income eligibility requirements, DSLC may be able to help modify their homes with ramps, lifts or other devices—at no charge.
- If clients are homeless, DSLC helps them find a place to live on their own, off the streets and free from fear.
- DSLC provides resources for specialized health care services the disabled must have, including finding insurance to cover their medical expenses.

DSLC is a legal advocate for equal justice, access, opportunity and participation in our communities, especially for clients, such as "Michael Hughes," who are denied benefits from state and federal programs they need to survive. ◇

Email: asbrown@sonic.net

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10. EEOC, "Facts about the ADA," www.eeoc.gov/facts (2008).

NEW MEMBERS

INDEPENDENT

Ryan Kime, MD, Emergency Medicine*, Windsor

David Kitts, MD, Surgery*, 652 Petaluma Ave. #D, Sebastopol, Med Coll Wisconsin 1985

Jonathan Rutchik, MD, Neurology*, 20 Sunnyside Ave. #A321, Mill Valley, Hahnemann Univ 1990

EYE CARE INSTITUTE

1017 Second St., Santa Rosa

Esther Penn, MD, Ophthalmology*, Vanderbilt Univ 1998

NCMA

3536 Mendocino Ave. #200, Santa Rosa

Kimberly Brayton, MD, Cardiovascular Disease*, UC San Francisco 2007

Vishal Patel, MD, Cardiovascular Disease*, Baylor Coll Med 2007

REDWOOD FAMILY DERMATOLOGY

2725 Mendocino Ave., Santa Rosa

Ligaya Park, DO, Dermatology, Western Univ

TPMG

401 Bicentennial Way, Santa Rosa

Adam Bellinger, MD, Urology*, Univ Texas 2008

Armand Braun, MD, Psychiatry*, Carol Davila Univ 1982

Hali Sherman, MD, Pediatrics*, UC Los Angeles 2003

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MYSTERY CASE

A Patient with Headache, Memory Loss and Unsteadiness

Allan Bernstein, MD

A 39-year-old female was seen in consultation for eight weeks of headache, memory loss and unsteadiness. The problems with her balance interfered with walking, driving and working. She worked for an oil company, but none of her co-workers reported any similar symptoms. The initial exam showed a truncal ataxia and dysarthria. She denied use of alcohol or street drugs. Her physician had prescribed 2–4 tablets/week of cyclobenzaprine 10 mg, a muscle relaxant. Concurrent illnesses were chronic hepatitis C, with unchanged liver function tests over five years, and episodic adult acne. The initial workup—including drug screening, metabolic panel, CBC, MRI and EEG—was normal.

Over the next two weeks the patient's symptoms progressed with increasing dysarthria, finger to nose ataxia and gait ataxia requiring use of a walker. There were no focal motor or sensory findings. Deep tendon reflexes remained normal. Psychiatric evaluation suggested depression and anxiety. Her acne actually was improving, which made her inappropriately happy in spite of her increasing disability.

She was given doxepin 30 mg/day for depression with mild improvement in her neurologic symptoms though her acne was increasingly symptomatic. Six weeks later, the neurologic symptoms increased again with disabling dysarthria and ataxia, although her acne was improving.

Her husband brought in all medications in the house, including OTC medications and cosmetics. One of them offered a clue to the diagnosis.

What's the diagnosis? Turn to page 45 for the answer. No peeking!

Dr. Bernstein, a Sebastopol neurologist, serves on the SCMA Editorial Board.

TOP 10 REASONS
To Join SCMA and CMA

Working together, the Sonoma County Medical Association and the California Medical Association are strong advocates for all physicians and for the profession of medicine. Of the many reasons for joining SCMA and CMA, 10 stand out:

1 COMMITMENT TO THE PROFESSION
By joining SCMA and CMA, physicians affirm their commitment to the profession of medicine and to preserving its honored place in modern society.

2 IMPROVING COMMUNITY HEALTH
SCMA is involved in several initiatives to improve community health in Sonoma County, such as increasing access for the uninsured and bolstering primary care.

3 LEGISLATIVE ADVOCACY
By speaking with a united voice, SCMA/CMA members exert a powerful influence on the political process at the local, state and national levels.

4 FOSTERING COLLEGIALITY
SCMA and CMA bring doctors from all parts of the medical community together—through leadership, cooperation and social gatherings.

5 FREE MEDICAL-LEGAL INFORMATION
CMA offers free medical-legal information on contracts, subpoenas, employee relations, collections and many other topics.

6 PRESERVING MEDICARE
Thanks to SCMA, CMA and other medical associations, recent attempts in Congress to cut the Medicare reimbursement rate have all been rebuffed.

7 PROTECTING MICRA
SCMA and CMA work diligently to protect the Medical Injury Compensation Reform Act (MICRA), which safeguards low liability insurance rates for California physicians.

8 PRACTICE MANAGEMENT
SCMA and CMA offer a wealth of resources to help physicians manage their practices, implement electronic medical records and qualify for federal incentive payments.

9 STAYING IN TOUCH
Through their magazines, newsletters and websites, SCMA and CMA encourage physicians to stay in touch with each other and with current medical news and events.

10 IT'S EASY AND FUN
To join SCMA and CMA, go to www.cmanet.org/join. Once you belong, it's fun to get involved in medical society projects and events.

ASK YOUR COLLEAGUES
ABOUT SCMA AND CMA

One of the best ways to learn more about the benefits of membership in SCMA and CMA is to ask your colleagues. The physicians listed below have leadership roles at SCMA and would be happy to take your call.

President
Regina Sullivan, MD
Obstetrics & Gynecology
707-393-4000
regina.t.sullivan@kp.org

President-Elect
Peter Sybert, MD
Anesthesiology
707-522-1800
pessramg@aol.com

Treasurer
Brad Drexler, MD
Obstetrics & Gynecology
707-431-8843
b9drexler@gmail.com

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Patricia May, MD
Surgery
707-393-4000
patricia.e.may@kp.org

Board Representative
James Pyskaty, MD
Pediatrics
707-393-4000
ym4djp@gmail.com

Immediate Past President
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Family Medicine
707-285-2970
mmgonzalez@rchc.net

RIGHT NOW
is the best time to join SCMA and CMA.

- **Contact Rachel Pandolfi at SCMA**
  707-525-4375 or rachel@scma.org.

–OR–

- **Join online**
  at www.cmanet.org/join

S · C · M · A

CMA

Biological Ambitions

Jeff Sugarman, MD

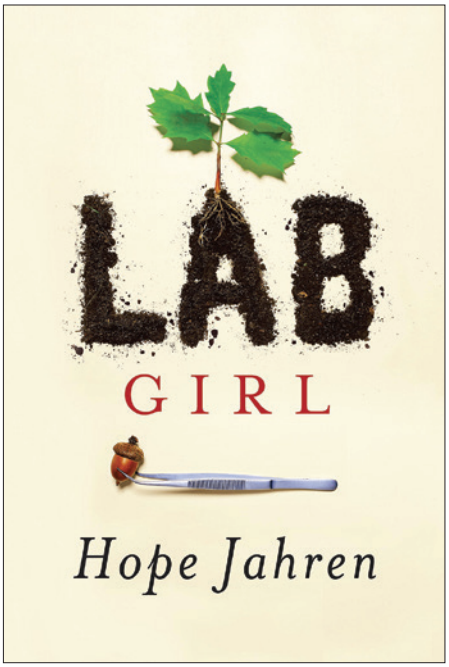
Lab Girl, Hope Jahren, Knopf, 304 pages (2016).

Anyone who has worked in a research laboratory knows the frustration of failure. Experiments go awry for good reasons—such as poor experimental design and improper hypothesis—and for trivial ones, such as power outage, measurement error or improper permits. Researchers, be they graduate students or professors, also know the thrill of discovery.

Reading *Lab Girl,* a memoir by Hope Jahren, PhD, brought me back to the experience of knocking my head against the wall in the lab while preparing my own PhD. (We both finished our PhDs in 1995, hers in soil science at UC Berkeley, mine in molecular biology at UC San Diego.) Her words about the joy of having knowledge that no one else in the world has will resonate with anyone who has done experimental research.

The three sections of *Lab Girl*—"Roots and Leaves," "Wood and Knots," and "Flowers and Fruit"—comprise a memoir of Jahren's life and scientific career, along with a lovely tour of plant biology. The memoir takes us from her childhood in a small Minnesota town, to her coming of age in graduate school at UC Berkeley, and finally to her academic success and acceptance.

By Jahren's own account, she is a fanatically hard worker. She rightly acknowledges, but does not dwell on, the tediousness of lab work, observing that



"like a lot a lab work that happens in the background, it wasn't very interesting . . . but had to be done carefully and without error." Much of the book traces the pain of her academic rejections at the hands of an impermeable good ol' boys club in the male-dominated world of geobiology research. According to Jahren, the club initially rejected her ideas because of their novelty and her gender. In her view, the academic world can often be myopic and slow to change, and new ideas may be threatening or misunderstood.

Many chapters in *Lab Girl* start with lovely metaphors relating the plant world to the human realm. "The first real leaf is a new idea," writes Jahren. "As soon as a seed is anchored, its priorities shift and it reflects all its energy toward stretching up. Its reserves have nearly run out . . . it has to work harder than everything above it." This last observation could well refer to Jahren's own struggles as a young scientist.

Although Jahren's early career was difficult, the tone she uses in her descriptions of her place in the academic world is too complaining at times. Her image of chewing on dog bones out of hunger is a bit much.

The plant world for Jahren is full of beauty, and she has a gift for making this world more visible through her writing. Her power with words lies in finding accessible metaphors for the biological systems most of us witness daily but do not fully appreciate. "A vine's only weakness is its weakness," she observes. "It desperately wants to grow as tall as a tree, but it doesn't have the stiffness necessary to do it politely. Vines are not sinister; they are just hopelessly ambitious."

Jahren's book is sprinkled with nuanced observations about the plant world. In contrast, her perception of the world of people is black and white. Perhaps influenced by her bipolar disease, she sees only two types of people: good ones and bad ones. The book often gets bogged down with these people, particularly with her defensiveness surrounding her relationship with her longtime assistant, Bill.

In the end, *Lab Girl* devolves into a series of personal vignettes that lose the thread of narrative. Nonetheless, Jahren makes an important plea for environmental sustainability. Her readers, armed with an enhanced appreciation of the "other world" of plants, may thereby become more adroit in their efforts to preserve our vanishing resources. ◇

Dr. Sugarman, a Santa Rosa dermatologist, chairs the SCMA Editorial Board.

Email: pediderm@yahoo.com

2016 wine & cheese reception

THE 16TH ANNUAL SCMA Wine & Cheese Reception was held in Kenwood on May 19 at Orpheus Wines, which is owned by Dr. Rachel Friedman and her husband, Marc Kraft. Several dozen physicians and their spouses attended the event, which included the ceremonial passing of the gavel and brief remarks by the outgoing president, Dr. Mary Maddux-González, and the incoming president, Dr. Regina Sullivan.

Above right: ***Dr. Mary Maddux-González passes the gavel to Dr. Regina Sullivan.***

Right: ***Dr. Ronald Van Roy, Dr. David Staples, Charlene Staples, Dr. Greg Sacher and Birgit Sacher.***

Top left: ***Dr. Enrique González, Dr. Jackie Senter, and Dr. Jan Sonander.***

Top center: ***Dr. Catherine Gutfreund and Dr. Steven Kmucha.***

Middle left: ***Dr. Regina Sullivan.***

Middle right: ***Orpheus owners Marc Kraft (winemaker) and Dr. Rachel Friedman (visioneer).***

Bottom: ***The assembled multitudes.***

Photos by Will Bucquoy

SONOMA COUNTY MEDICAL ASSOCIATION

S · C · M · A

To All Sonoma County Physicians:

The Sonoma County Medical Association has worked for more than 150 years to address the opportunities and challenges facing local physicians and their patients. SCMA owes its success to setting and resetting goals relevant to the ever-changing health care environment, and to the many physicians throughout the years who have provided effective leadership.

This past spring, the SCMA Board of Directors initiated a strategic planning effort and distributed an extensive survey to solicit input from all practicing Sonoma County physicians—SCMA members and nonmembers alike. We also sought guidance from other health care organizations, public health agencies and nonprofit organizations.

At their March retreat earlier this year, the SCMA board included feedback from the survey to update SCMA's mission, vision and values statements and to refresh the association's five key strategies.

The resulting **Strategic Plan**, approved by the SCMA board in May, provides guidance for our work over the next three years. The plan focuses on how we will serve our membership and have the greatest positive impact on our community, working collaboratively to improve local health care. The plan also lays out our priorities and aligns SCMA activities so we can measure our success along the way.

SCMA is fortunate to benefit from physician participation and from collaborative opportunities with other organizations. We would like to thank these physicians and organizations for their contributions to our new Strategic Plan. We believe their efforts will be rewarded with a more cohesive and relevant SCMA.

Cordially,

Regina Sullivan, MD
SCMA President

Mary Maddux-González, MD
SCMA Past President

WORKING FOR YOU

2016–19 SCMA Strategic Plan

Mission Statement

To enhance the health of our patients and community; promote quality, ethical health care; and foster strong patient-physician relationships and the personal and professional well-being of physicians through leadership, partnership and advocacy.

Vision Statement

Leading Sonoma County into better health

Values

• *Quality* • *Well-Being* • *Advocacy* • *Collaboration* • *Integrity*

Strategies and Goals

LEAD CHANGE IN HEALTH CARE SYSTEM DELIVERY

- Continue to support efforts to increase enrollment and retention in health insurance and other coverage options
- Advance legislative and regulatory advocacy for patient-physician and physician issues
- Support access to needed care and services
- Ensure physician voice in development and implementation of payment reforms
- Increase participation in, and development of, health information exchanges
- Serve as a central repository for local issues to pass forward to other entities

ADVOCATE FOR A HEALTHY COMMUNITY

- Provide physician leadership and advocacy on priority community health issues, including social determinants to health
- Participate in specific community health initiatives and bring efforts back to organizations to create practice-level change
- Provide physician leadership on educating the community about health issues
- Reduce obesity in the community
- Promote physician awareness of emergency preparedness, response needs and options for participation in community

ADVOCATE FOR PHYSICIAN PRACTICE VIABILITY AND PHYSICIAN WELLNESS

- Advocate for all modes of practice viability
- Promote a healthy lifestyle for physicians

ENSURE A VIABLE MEMBERSHIP LEVEL TO SUSTAIN AND GROW SCMA

- Communicate value of membership
- Engage in retention and recruitment efforts

STRENGTHEN SCMA THROUGH ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY

- Develop physician involvement
- Refine SCMA governance

Strategic Plan Goals and Related Actions

CONTINUE TO SUPPORT EFFORTS TO INCREASE ENROLLMENT AND RETENTION IN HEALTH INSURANCE AND OTHER COVERAGE OPTIONS

- Promote continued enrollment and retention
- Target the remaining uninsured
- Promote health insurance literacy and knowledge about how to utilize
- Partner with existing safety net enrollment and retention programs

ADVANCE LEGISLATIVE AND REGULATORY ADVOCACY FOR PATIENT-PHYSICIAN AND PHYSICIAN ISSUES

- Build and strengthen relationships with legislators and regulators
- Educate physicians about SCMA/CMA advocacy role and encourage participation
- Build and strengthen SCMA's participation and influence in CMA

SUPPORT ACCESS TO NEEDED CARE AND SERVICES

- Promote access to primary and specialty care
- Promote access to mental health and substance abuse services
- Promote access to dental care

ENSURE PHYSICIAN VOICE IN DEVELOPMENT AND IMPLEMENTATION OF PAYMENT REFORMS

- Educate the physician community about upcoming changes
- Participate in local efforts and options regarding pilot programs

INCREASE PARTICIPATION IN, AND DEVELOPMENT OF, HEALTH INFORMATION EXCHANGES

- Educate physicians on existing structure
- Provide updates on how HIEs are evolving

SERVE AS A CENTRAL REPOSITORY FOR LOCAL ISSUES TO PASS FORWARD TO OTHER ENTITIES

- Form Physician Aid in Dying Workgroup to define SCMA's role as a repository of information and resources

PROVIDE PHYSICIAN LEADERSHIP AND ADVOCACY ON PRIORITY COMMUNITY HEALTH ISSUES, INCLUDING SOCIAL DETERMINANTS OF HEALTH

- Education
- Income and economic well-being
- Access to tobacco
- Access to fluoridation

PARTICIPATE IN SPECIFIC COMMUNITY HEALTH INITIATIVES AND BRING EFFORTS BACK TO ORGANIZATIONS TO CREATE PRACTICE-LEVEL CHANGE

- Opioid safety
- Cardiovascular disease/Hearts of Sonoma
- Latino Health Forum
- Asian Pacific Islander Health Forum

PROVIDE PHYSICIAN LEADERSHIP ON EDUCATING THE COMMUNITY ABOUT HEALTH ISSUES

- Marijuana
- Aid in dying
- End-of-life care planning

REDUCE OBESITY IN THE COMMUNITY

- Work toward prevention of diabetes
- Promote healthy eating and active living
- Support decreased intake of sugar-sweetened beverages
- Foster awareness of sleep apnea
- Continue partnerships with other organizations and programs

PROMOTE PHYSICIAN AWARENESS OF EMERGENCY PREPAREDNESS, RESPONSE NEEDS AND OPTIONS FOR PARTICIPATION IN COMMUNITY

ADVOCATE FOR ALL MODES OF PRACTICE VIABILITY

- Survey physicians to better understand needs
- Create an action plan based on survey results
- Identify and inform physicians of available practice resources
- Develop Practice Managers Forum

PROMOTE A HEALTHY LIFESTYLE FOR PHYSICIANS

- Increase promotion of SCMA Alliance Foundation
- Support advocacy to reduce bureaucratic impact on physicians
- Participate in Doctors Day
- Provide membership with information about physician burnout

COMMUNICATE VALUE OF MEMBERSHIP

- Continue to define membership value for various modes of practice
- Continue to define "return on investment" for various modes of practice
- Provide SCMA/CMA update at hospital and group staff meetings
- Educate and promote participation in CMA House of Delegates

ENGAGE IN RETENTION AND RECRUITMENT EFFORTS

- Continue and expand the Value of Membership campaign
- Develop group membership campaign
- Develop sponsorship campaign for businesses
- Offer innovative dues and payment plans

DEVELOP PHYSICIAN INVOLVEMENT

- Identify and communicate opportunities for involvement (e.g., leadership "farm team")
- Promote board member recruitment
- Create a repository for physician volunteer and work opportunities on the SCMA website

REFINE SCMA GOVERNANCE

- Update bylaws
- Evaluate and strengthen SCMA policies approved by the board of directors
- Review annually the need to appoint/reappoint committees and their commission of work statements

MYSTERY CASE SOLUTION

The likely etiology of the waxing and waning of the patient's neurologic symptoms was topical tretinoin (Retin-A). This is a potent retinol, effective against acne. Like all retinols, in high doses it can cause cerebral edema with diffuse neurologic dysfunction, including death due to herniation. The patient's symptoms were primarily cerebellar, in keeping with the cerebellar Purkinje cells' extreme sensitivity to a multitude of toxins.

Making the diagnosis was difficult because the patient got the tretinoin from a friend, not from a prescription. The patient considered tretinoin a cosmetic, not a drug, since it effectively cleared up her skin issues. In retrospect, the fact that her skin got better while her neurologic symptoms got worse, and reversed in the same pattern, might have given us a clue to the diagnosis. An additional issue was the patient's hepatitis C. Although her liver function tests were in the normal range, her capacity to properly store and potentially detoxify the retinol may have been impaired. The ability to conjugate retinoic acid to an excretable form is a function of retinol-binding proteins produced in the liver.

Topical tretinoin is known to cause itching, and patients are warned not to scratch, but no formal information was given in this case. The transcutaneous absorption of tretinoin is considered less than 5%, when used according to directions. The patient admitted to scratching herself when the medication caused itching, probably increasing the absorption.

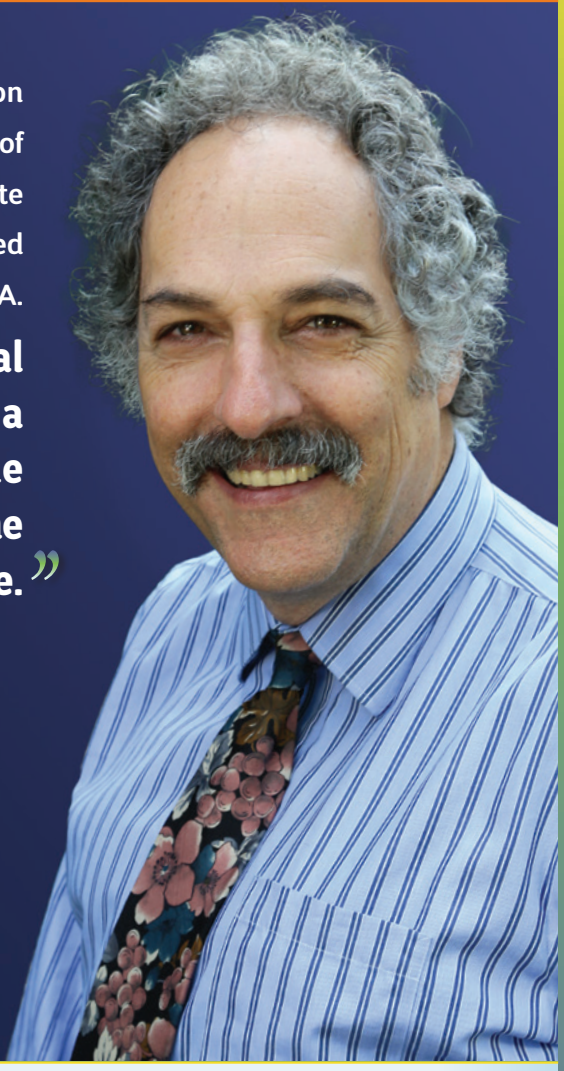
After the patient stopped administering topical tretinoin, her symptoms entirely cleared in two weeks. They did not recur during subsequent visits over the next year. ◇

Email: bernsteinallan@gmail.com

Value of Membership

PRACTICE ◆ PROFESSIONAL ◆ PERSONAL

"No other organization commands the level of respect in the state capitol as does organized medicine and the CMA. **In the political world, having a seat at the table makes all the difference.**"



BRAD DREXLER, MD
Obstetrics & Gynecology
SCMA Treasurer, Past President
b9drexler@gmail.com
431-8843

COMPLETE LIST of MEMBER BENEFITS page 34

Why **SOLO/SMALL-GROUP PRACTICE PHYSICIANS** *should be SCMA/CMA members:*

1. I've used CMA's **small practice resources** frequently. They've helped with billing and payment problems, contracting issues, and regulations and compliance.
2. SCMA and CMA were essential in our recent fight to save MICRA (California's malpractice liability reform law), thereby allowing physicians to continue to afford practices in our expensive state—**there's no way to even put a price on how valuable this victory was to solo and small-group physicians!** CMA is also vigilant in protecting our scope of practice and preventing politicians from invading our decision making.
3. **Grow your professional network and referral list** by connecting with peers, established local physicians, health care leaders and legislators at SCMA/CMA events. SCMA is the only organization in our community where physicians from all regions and hospitals, as well as all practice modes, are able to meet, get together, and network. **There is strength in numbers!**

Join SCMA / CMA Now! ▪ 707-525-4375 ▪ cmanet.org/membership

2016 ANNUAL AWARDS

Dear Colleague:

The SCMA Awards Committee is seeking nominations for the **2016 Annual Awards,** which honor physicians who have demonstrated sustained and exemplary service. The awards, to be presented at the Annual Awards Dinner on Dec. 6, 2016, reflect a significant tribute of respect, recognition and appreciation from SCMA membership. Awards are also given to nonphysicians who have made significant contributions to the advancement of medical science, medical education or medical care. The four awards are as follows:

Outstanding Contribution to the Community

Presented to an SCMA member whose work has benefited the community

Outstanding Contribution to Local Medicine

Presented to an SCMA member who has improved local medical care

Outstanding Contribution to SCMA

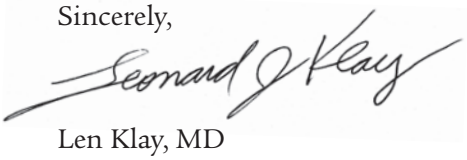
Presented to an SCMA member who has served the medical association beyond the call of duty

Recognition of Achievement

Presented to a nonphysician who has helped advance local medicine

Past recipients are listed on the following page. Physician candidates must be SCMA members, and may be nominated for more than one award. Please use the form below and return your nominations **by Friday, Aug. 19.** For more information, contact Cynthia Melody at 707-525-4375 or cmelody@scma.org.

Sincerely,



Len Klay, MD
Past President and Awards Committee Chair

SCMA 2016 Annual Awards Nomination

To: Len Klay, MD

From: _____
(Name required)

Nominee: _____ **Award:** _____

For more than one nomination, submit separate forms for each. Please provide support information, including accomplishments and contributions, that will help the Awards Committee evaluate your nominee for the award selected. Nominations must received at SCMA **by 5 p.m. on Friday, Aug. 19.** Submit any of the following:

Fax to **707-525-4328**
Email to **scma@scma.org**
Mail to **SCMA, 2312 Bethards Dr. #6, Santa Rosa, CA 95405**

THREE DECADES OF AWARDS RECIPIENTS

	Outstanding Contribution to the Community	Outstanding Contribution to Sonoma County Medicine	Outstanding Contribution to SCMA	Special Award for Recognition of Achievement
1985	R. Lee Zieber, MD	James Gude, MD	John Kenney, MD	
1987	Frank Norman, MD		Joseph Schaefer, MD	
1988	Horace Sharrocks, MD		Robert Butler, MD	
1989	Carroll Andrews, MD John Roberts, MD	Richard Barnett MD	Carl Anderson, MD	
1990	Marshall Kubota, MD	Louis Menachof, MD	Ransom Turner, MD	
1991	William Ellison, MD	Harry Ackley, MD	James Clegg, MD	
1992	Harding Clegg, MD Tetsuro Fujii, MD	John Reed, MD	L. Reed Walker Jr., MD	
1993	Thomas Honrath, MD	Lucius Button, MD		
1994	John Sweeney, MD	William Dunn, MD	Thomas Maloney, MD	Helen Rudee
1995	Kenneth Howe, MD	Maurice Carlin, MD Winston Ekren, MD	Leonard Klay, MD	
1996	Gary Johanson, MD Harry Richardson, MD	Michael Gospe, MD	Jerome Morgan, MD	Brother Toby
1997	Salute to Community Service	Salute to Community Service	Salute to Community Service	
1998	Gregory Rosa, MD	James McFadden, MD	Donald Van Giesen, MD	Daryl Schloss
1999	Chris Kosakowski, MD Brian Schmidt, MD	Mark DeMeo, MD	Clinton Lane, MD	
2000	Katherine Walker, MD	Frank Miraglia, MD	Cynthia Bailey, MD	Steve Osborn /Joan Chilton
2001	Jeffrey Miller, MD	Robert Huntington, MD	William Meseroll, MD	Andrea Learned /Larry McLaughlin
2002	Bob Schultz, MD	Louis Menachof, MD	Paul Marguglio, MD	Cynthia Melody/Harry Polley/ Assemblywoman Patricia Wiggins
2003	Amy Shaw, MD	Brien Seeley, MD	Ron Van Roy, MD	Elizabeth Chicoine/Cheryl Negrin-Rappaport
2004	Michael Martin, MD	Jan Sonander, MD	Dan Lightfoot, MD	Sharon Keating
2005	Richard Powers, MD	Mary Maddux-González, MD		Medicare Campaign Leaders
2006	Rick Flinders, MD	Leigh Hall, MD	Lynn Mortensen, MD	Robert Pelligrini
2007	Jose Morales, MD	James Gude, MD	Phyllis "Jackie" Senter, MD	Kay Reed & David Anderson, MD
2009	Walt Mills, MD	Jeff Sugarman, MD	Brad Drexler, MD	Santa Rosa Family Medicine Residency Consortium
2010	Stacey Kerr, MD	Lyman "Bo" Greaves, MD	Richard Andolsen, MD	
2011	Allan Bernstein, MD	Enrique González-Méndez, MD	Kirk Pappas, MD	Operation Access
2012	Jeff Haney, MD	Mark Netherda, MD	Catherine Gutfreund, MD	Redwood Community Health Coalition
2013	Robert B. Mims, MD	Peter Brett, MD	Walt Mills, MD	Northern California Center for Well-Being
2014	Joe Clendenin, MD	Laurel Warner, MD Charles Elboim, MD		Ritch Addison, PhD
2015	Richard Powers, MD	Congressman Mike Thompson, Brad Drexler, MD/Len Klay, MD/ Jan Sonander, MD	Medical Review Advisory Committee	SCMA Alliance Foundation Holiday Greeting Card

Save the Date!

Join us for the annual

SCMA Awards Dinner at Vintners Inn

Tuesday, Dec. 6, 2016

Watch for details at www.scma.org, in the monthly *News Briefs,* and in the fall issue of *Sonoma Medicine.*

ABOUT OUR PUBLICATIONS

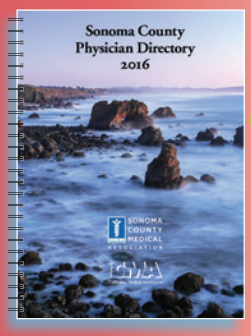
The **Sonoma County Medical Association** has a long history of producing quality publications for the local medical community. Whether you're an advertiser trying to reach local doctors, a business needing access to medical resources, or a reader interested in medical topics, SCMA has a publication for you. Our magazines, newsletters and directories are widely distributed throughout Sonoma County and beyond.

TARGET YOUR MESSAGE

to physicians and medical professionals in . . .

SONOMA MEDICINE

Each issue of this quarterly magazine focuses on a particular medical theme, with articles by local experts. To see the current issue, visit **scma.org** and click on *Sonoma Medicine,* where you can view an interactive PDF and searchable, text-only versions of previous issues.



SONOMA COUNTY PHYSICIAN DIRECTORY

Our annual reference book provides contact information for physicians in Sonoma County, plus detailed specialty indexes and medical resources. For ad rates, or to purchase a copy, visit **scma.org** and click on the Directory link.

NEWS BRIEFS

The monthly e-newsletter covers local medical news and events, along with top CMA benefits and news. To view current and archive issues, go to **scma.org** and click on *SCMA News Briefs.*

AWARDS DINNER PROGRAM

Published in December, the annual Awards Dinner program offers a once-a-year opportunity to reach an influential group of Sonoma County health care leaders. To reserve space as a sponsor or program advertiser, call Susan Gumucio.

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*Contact **Susan Gumucio** at **susan@scma.org** or **707-525-0102.***

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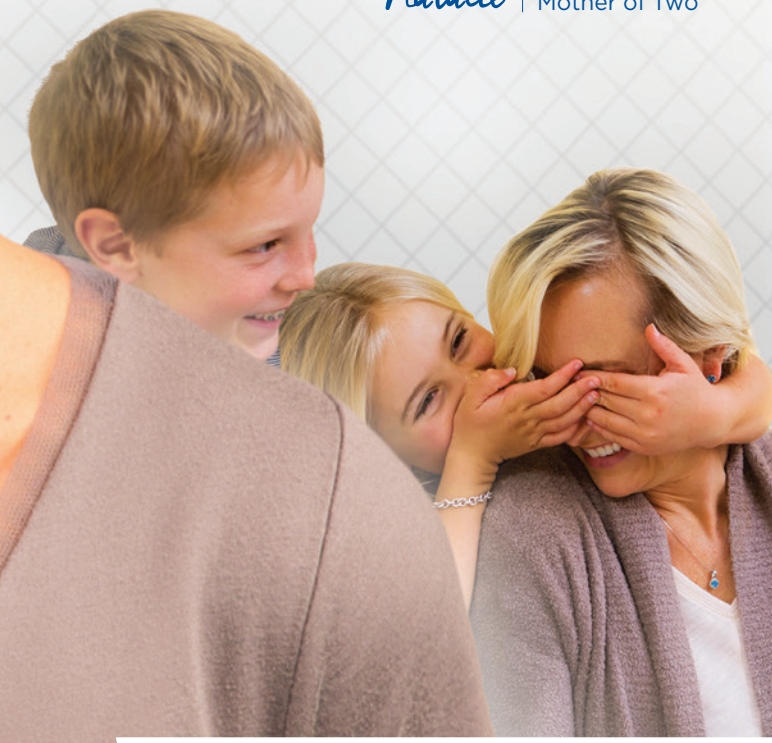
EXPERT CANCER CARE, **CLOSE TO HOME.**

I'll Never Forget...

fighting my cancer as hard as I could for my kids. I had multiple surgeries and months of aggressive chemo and radiation treatments. Dr. Elboim and the team at St. Joseph Health did everything they could to save me, and it worked. **They gave my kids their mommy back.**

Natalie | Cancer Survivor
Mother of Two



Learn more about Natalie's story:
StJoeSonoma.org/Cancer

A Ministry founded by the Sisters of St. Joseph of Orange

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